PSYCHIATRIC COMMUNITY NURSING:
A STUDY OF A WORKING SITUATION

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1977

I declare that this thesis has been composed by myself, and that the study reported in it was my own work.

ABSTRACT

A descriptive account is presented of a community psychiatric nursing service based at a psychiatric teaching hospital in Edinburgh. The object of the study was to contribute to the identification and analysis of the role and functions of community psychiatry nurses.

The study was focused mainly on nurse-patient contact and on the process and content of nurse-patient interaction.

The fieldwork for the study was carried out in 1972-73. The main instruments used were self-administered record schedules reporting nurses' contacts with patients and their families and interviews to obtain background information on factors which influenced the nurses' activities.

It was found that the service was functioning mainly as an after-care agency. A high proportion of the work of the service took place in a hospital context; the case-load had close connections with hospital care, and the nurses mainly called on hospital resources and staff in support of their work. It was concluded that the staff were acting primarily as intermediaries between the patient and the hospital, and that their direct care functions were secondary to this.

Factors which influenced the activities of the nurses included role concepts, role-relationships (which presented some problems) and the needs of the patient and his family. A combination of clinical-psychiatric and psycho-social needs were observed and it was inferred from the evidence that the former were better catered for than the latter. Particular problems in family relationships were recognised. It was concluded that the situation demanded enhanced skills which could be developed through supervised practice. It was also suggested that the functions and case-loads of community psychiatric nursing services were profoundly influenced by their location and organisation, and that these should, therefore, be decided in the light of an explicit formulation of desired objectives.

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ACKNOWLEDGEMENTS

Social research is nearly always a cooperative enterprise. So many individuals have helped towards the completion of this work that I cannot mention them all; but I ask everyone concerned to accept my gratitude.

First and foremost my thanks are due to the staff of the community psychiatric nursing service of the Royal Edinburgh Hospital in 1972–73, for exposing themselves and their work to the process of enquiry, answering endless questions and patiently supplying innumerable data.

Among those who helped with the planning, execution and reporting of the study, I am especially grateful to Dr. J.W. Affleck and Mr. John G.Sutherland for supplying the initial impetus; to my academic supervisors, Dr. Affleck and Miss Ruth Schröck, for their enthusiasm and patience; to my Steering Group for their support; and particularly to Miss Dorothy Buglass for her most constructive help and advice at all stages of the work.

I should also like to thank Mr. William Watson and other staff of the Edinburgh Regional Computer Centre for assistance in the preparation and manipulation of the data; Mr. John MacFarlane and Mr. Brian Perry of the University of Strathclyde for help with the analysis of the 'activities' data; and Mr. William Black (lately of the Scottish Home and Health Department) and Professor Annie Altschul for valuable comments on previous drafts of the report. The Nursing Research Unit of the University of Edinburgh has provided me with a base throughout the work, and I am very grateful to the Unit's Director and staff for their friendly help and encouragement.

Many nurses were good enough to help me in the exploratory stages of the study and in the development of the research instruments. Among them my thanks are due particularly to the psychiatric community nursing staffs of All Saints Hospital, Birmingham and of the Royal Dundee (Liff) Hospital, who carried out trials of the data schedules for the main study.

Finally I should like to acknowledge the support of the Scottish Home and Health Department which financed the study.

SECTION I. INTRODUCTION. THE BACKGROUND OF CLINICAL AND ADMINISTRATIVE CHANGE

This study was prompted by the development of community psychiatric nursing services in Great Britain which took place in the 1960s, and the uncertainties which arose about the psychiatric nurse's role in domiciliary and community care. This development was only one aspect of a process of radical change in approaches to mental illness, concepts of psychiatric treatment, clinical practice and administrative structures. To explain the context of the study, a brief discussion of these changes follow. Literature about some aspects which are directly relevant to the planning and interpretation of the study will be discussed in a following section.

It became apparent in the early 1950s that new patterns of hospital care were developing in psychiatry. Policies of active short-term treatment and early discharge were progressively reducing the number of occupied beds in mental hospitals. This trend prompted the famous prediction of Tooth and Brooke (1961) that by 1975 the existing long-stay population of mental hospitals in England and Wales would have virtually disappeared. This prediction was immediately challenged on methodological and other grounds (Jones and Sidebotham 1962; Rehin and Martin 1963; Gore et al. 1964; Baldwin 1968a), but nevertheless it guided the formulation of policy in the 1962 Hospital Plan for England and Wales (Ministry of Health 1962) which envisaged the eventual replacement of the traditional large, isolated mental hospitals by much smaller psychiatric units in district general hospitals. More recent statistics for England and Wales show a continued reduction in the ratio of psychiatric in-patients to the total population, along with increasing rates of admission and patient turnover (Department of Health and Social Security 1974). The incorporation of the prediction in official policy made it, in effect, a self-fulfilling prophecy. In Scotland, where such a policy was not adopted, the trend was less marked (Baldwin 1968b). The Scottish Hospital Plan was less radical, envisaging the retention of most of the existing mental hospitals, which were generally smaller and less remote from the populations served than the English hospitals; action has been taken to rationalize catchment areas in relation to the

location of hospitals, and to reduce overcrowding and problems of scale by reducing in-patient populations.

The doctrine of 'community care', as enunciated in 1957 by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, stated that people should not be in hospital unless they were so acutely or chronically disturbed that they required 24-hour nursing and medical attention.

The changed use of hospital accommodation meant that there would be increasing numbers of people 'in the community' who were in the process of recovering from or relapsing into acute psychiatric disorder, or suffering from some degree of chronic or recurrent psychiatric disability. The question of how to care for larger numbers of disturbed people in the community was largely left to the initiative of the local authorities, which were responsible for providing a range of health and welfare services (residential facilities; rehabilitative and occupational services; domiciliary supervision and social care) in the community. The powers of local authorities in these respects were not mandatory, and no minimum standards were laid down for the country as a whole. There was no systematic attempt to coordinate the planning of hospital and other services in the same areas. As a result of the lack of coordinated planning and of the division of responsibility between the various arms of the National Health and local authority services, extra-hospital facilities in many areas proved inadequate to meet the new demands thrown on them by the changes in hospital occupancy, and there were large discrepancies in standard of provision of such services between one area and another (Martin and Rehin 1969).

Many hospitals and health authorities responded to these problems by seeking new methods of improving their extra-mural services. Efforts at coordination were made in some areas between the various agencies involved (Rehin and Martin 1968), and a variety of methods and patterns of care were evolved. The deployment of psychiatric nurses from hospitals into the community was one of these.

Collaborative relationships at some level between the hospital and psychiatric services on the one hand, and the mental health services of local authorities on the other, were established in most areas. These relationships were disrupted by the comprehensive

reorganization of the health and social services, beginning (in 1969 in Scotland) with the creation of all-purpose Social Work Departments within local authorities. The functions of local health authorities in respect of mental health and mental illness were divided between the new Social Work Departments and the reorganized National Health Service. Specialist services for Mental Health work ('Mental Welfare' in England and Wales) were absorbed into 'generic' social work agencies. Social workers without psychiatric training or experience were in general not adequately prepared to fulfil the functions traditionally performed by Mental Health Officers (many of whom had received an initial training in psychiatric nursing) in the after-care of discharged psychiatric patients, the supervision of drug regimes and the management of psychiatric emergencies (Affleck and Forrest 1971). These changes left a gap in provision which psychiatric nurses in the community could fill.

Maintenance and regulation of drug therapies is an important aspect of psychiatric care in the community. A study of discharged schizophrenic patients (Renton et al. 1963) has shown that failure to take drugs as prescribed was associated with a less satisfactory level of social adjustment. The so-called 'revolving door' phenomenon - in which early discharge was followed by the patient's early breakdown and by a pattern of frequent readmission, short-term treatment, early discharge and rapid relapse - was probably also partly due to patients' failure to persist with drugs (although there is no conclusive evidence for this). This problem was alleviated by the introduction in the mid-1960s of long-acting drugs of the phenothiazine group (and other major tranquillizers) which can be given by injection and which have a sustained effect for periods of up to a month or even longer. The development of community psychiatric nursing services - already established in some areas - appears to have been stimulated by the introduction of these drugs, which created a demand for qualified nursing staff experienced in the use, effects and side-effects of psychotropic drugs to administer them to patients in the community and to undertake a general supervisory and after-care function.

This opportunity was seized by psychiatric nurses who were dissatisfied with the traditional role of the nurse in mental

hospitals, expected it to decline, and wished to extend their range to include the care of patients in their normal family and social environment. In this they were merely following general tendencies in concepts and attitudes towards mental disorder and psychiatric care. Nurses could not be immune to the prevailing climate of distrust for institutional care, nor could they remain unaware of alternative definitions of psychiatric disorder, substituting for the established 'medical model' of 'illness-treatment-cure', alternative definitions in terms of 'problems of living' (Szasz 1961) or of deviation from oppressive social norms (Scheff 1966). The logical consequence of these ideas was to doubt whether hospitals were the best place to deal with disorders which could not be shown to be of biological origin.

A succession of official conferences, committees and working parties has recommended the recognition of an extended role for the psychiatric nurse, adding 'an interpersonal concept of patient behaviour to an intrapersonal one', 'including the community in its focus' and shifting from custodial to therapeutic tasks through the development of 'interpersonal skills that enable her to work with patients in therapeutic experiences' (WHO 1956; see also WHO 1957, 1971; SHHD 1972; Committee on Nursing 1972). Several of these statements have laid stress on the nurse as providing continuity and as integrator of the patient's care in all its phases.

Community psychiatric nursing services evolved in different settings in many and various ways; in some, ward-based nurses followed patients into 'the community' in an informal and ad hoc way, or on a more organized part-time or rotating basis. At other centres full-time nurses were appointed specifically for 'community' work based upon psychiatric hospitals and departments, day hospitals, community nursing services or health centres. The development of community psychiatric nursing services brought to light uncertainties about the proper functions of psychiatric nurses in the community; the training, experience and support which they need; and their role-relationships in their new working situation with members of other disciplines, particularly social work (Smith 1969). The diversity of the organization and structure of services contributed to the

difficulty of defining the nurse's role and role-relationships in the community situation. Two of the issues were succinctly stated by Altschul (1969):

> "The first question is whether or not the nurse brings to the work specific knowledge or skills, different from those of the social worker, and whether the nurse's learning or experience result in a different mode of functioning from that of other professional people".
>
> "The second question is whether the patient has specific nursing needs, as distinct from social needs, and whether some patients require the nurse as a person, rather than the social worker, to satisfy those needs".

Though some of the uncertainties have been resolved in the light of experience and of changed circumstances, the major questions still remain. How are comprehensive services to be provided outside hospital for people suffering from mental disorders? What are the special needs of their families and others concerned with them? When (if at all) is the psychiatric nurse the worker best equipped to meet these needs? Does she contribute anything which is essentially a nursing attribute or function, or is she merely providing a (cheaper and less highly qualified) substitute for inadequate psychiatric, health visiting or social work services?

If general agreement is assumed that an appropriate nursing task exists and is being fulfilled, then further questions arise: What further preparation do psychiatric nurses require for their work in the community situation in addition to their existing hospital-oriented training and experience? Does the work in fact require the special skills of psychiatric nurse, or could it be carried out equally well by a less specialized or less highly qualified nurse, or by a lay person?

These questions should not only concern psychiatric nurses, but also health service administrators whose job is to provide, in the public interest, the best possible service at the least practicable cost; community nurses and other professionals who want a mutual definition of roles which preserves their own status and functions; and (most of all) they concern the patients and their families who want an efficient and humane service, but who have prejudices and preferences about how and by whom it should be provided.

There can be no useful discussion of these problems without a basis of accurate information about the tasks which community psychiatric nurses are called on to undertake. This is the justification for the investigation reported here. But the research worker exceeds his brief if he seeks to pre-empt the process of decision. Where matters of value and expediency are in question, facts (however reliable and valid) are no substitute for the exercise of judgement. Research could not, and should not, set out to provide answers to many of the questions posed above. What it may do is to provide a starting point for discussion of the objectives and values on which decisions should be based.

SECTION 2: THE SETTING OF THE STUDY

The idea of commissioning a study of the community psychiatric nursing service based at the Royal Edinburgh Hospital was conceived by senior members of the hospital's medical and nursing staff. In the face of the issues outlined at the end of the last section, it was hoped that such a study would contribute to a satisfactory definition of the psychiatric nurse's role in the community. The proposal was encouraged by the Scottish Home and Health Department which agreed to provide financial support for the expenses of a research worker for a period of two years.

The writer was invited to undertake the research and was appointed as a member of the nursing staff of the hospital. Her interest in the project arose from experience in nursing in both general and psychiatric hospitals. She had become convinced that nursing care in either setting was more effective where nursing staff had both the opportunity and the capacity to observe, comprehend and (if appropriate) intervene in the personal and social environment from which the individual patient brought his 'illness' for treatment or care. She hoped that the study might make a contribution to nurses' increasing consciousness of the psycho-social dimension of their work, and might help to encourage more flexible forms of training and practice, at least in psychiatric nursing.

The writer herself had gained some experience of working as a psychiatric nurse in a multi-disciplinary team structure operating from a hospital base in community settings, in which diffusion of roles within the teams was practised. She had become interested in the question whether the contribution of individuals to the teams' activities was determined primarily by professional or personal factors - viz: by individuals' professional training, experience and prescribed roles, or by their personal talents, preferences and characteristics.

The Department of Nursing Studies of the University of Edinburgh agreed to be associated with the project and accepted the writer as a postgraduate student. Academic supervision was given jointly by that department and by the Department of Psychiatry.

Much of the work was carried out in the Nursing Research Unit at the University of Edinburgh whose Director and staff gave consistently helpful support and guidance. Advice and help was also generously given by members of the MRC Unit for the Epidemiology of Psychiatric Illness.

The planning of the project was guided by a steering group including representatives of the Scottish Home and Health Department, the University Departments of Nursing Studies and of Psychiatry, the MRC Unit for the Epidemiology of Psychiatric Illness, and senior medical and nursing staff of the hospital. (The membership of the group is listed at Annex 2). The writer is very grateful to the members of this group for their encouragement and support and for the time and interest which they gave to the project. Nevertheless it should be made clear that the design and execution of the study and the preparation of this report were entirely the responsibility of the writer at whose door its defects should be laid.

The Royal Edinburgh Hospital, at which the service to be studied was based, is a psychiatric institution with a long and distinguished history. It was set up under Royal Charter at the initiative of an Edinburgh physician, Dr. Andrew Duncan, and was opened in 1813. It came to include three constituent institutions closely linked but with distinctive characters:

> The original royal asylum, a non-profit-making institution which, until 1948, accommodated mainly patients placed there by local authorities. This was one of the earliest of the public asylums to be built in Scotland; it was partly financed from public subscriptions, and had better staffing levels than most Scottish district asylums.
>
> A private hospital with imposing buildings set in extensive grounds, built in the early 1900s for the accommodation of paying patients.
>
> A unit providing acute admission facilities, short-term in-patient care and out-patient treatment. This unit was opened in 1928 to provide facilities for acute psychiatry on an informal basis. It has since been extended and reorganized.

The hospital is situated near the middle of its catchment area in a district of substantial residential property, and is easily accessible from the city centre. Since 1948 there have been extensive additions to the buildings and changes in the functions of the various parts of the hospital, the main one being that it is now responsible for psychiatric in-patient and out-patient services under the National Health Service, and for a finite catchment area with a population of (in 1972) about 3 00,000.

At the time of the field-work for this study, recent changes in the internal organisation of the hospital (including the implementation of the Report of the Committee on Senior Nursing Staff Structure - the "Salmon Committee"), were tending to obscure the last traces of the three separate institutions and to promote more homogeneous forms of organisation, especially in nursing management. The identities of the three original parts of the hospital were still manifest in their architectural styles, and the hospital as a social institution had a heterogeneous character which probably originated in the diverse traditions and environments which it embraced.

The clinical facilities of the hospital in 1972 included roughly 1,000 in-patient places, as well as facilities for day-patients and out-patient care. About a third of the in-patient accommodation was used for psychogeriatric cases, and a third for long-stay psychiatric patients for whom active rehabilitation and behaviour modification programmes were in operation in several wards. There were 44 hostel places used for rehabilitation of patients with chronic or long-term problems; the hostels provided experience of living at graduated levels of independence in order to prepare patients for discharge to normal social environments. Five general service units providing about 180 beds dealt with acute admissions and short-term treatment. In addition there were several specialised units offering treatment for particular types of patient or conditions.

Day-patient and out-patient services were conducted on the main hospital site. In 1972 nearly 19,000 out-patient attendances were recorded, of which 2,000 were first attendances. Roughly 100 people were attending the hospital as day-patients at any one time; the total day-patient attendances for 1972 were 22,500. Facilities for

day-patients were offered by two day-hospital units, the occupational therapy work-shops and departments, and wards of all types.

A number of autonomous clinical teams were responsible for clinical services for patients inside and outside the hospital. Each team looked after one or more wards or in-patient units and also provided out-patient and domiciliary services. The teams included psychiatrists, psychologists, social workers and nurses. Occupational therapists were also attached to certain wards or units. Trained nurses were considered as integral members of the clinical teams, but in contrast with other members their activities were largely confined to the ward or unit.

Many shades of opinion and varieties of clinical practice were represented within the hospital, but no particular ideological position was predominant, and none was carried to an extreme position. In most areas clinical methods of treatment were eclectic. Each team or unit developed its own philosophy and policies. A degree of unanimity between different areas of the hospital was maintained through unified administrative structures and professional groups, and through periodic movements of staff in training.

In addition to its clinical functions the hospital has major commitments to research and teaching. It is associated with the Department of Psychiatry of the University of Edinburgh and with two units of the Medical Research Council, all of which are located within the grounds of the hospital. Clinical experience and teaching are provided in the hospital for students and trainees in nursing, psychiatry, general medicine, clinical psychology, social work and occupational therapy. Numerous senior workers in various disciplines are thus attached to the hospital's staff, and the staff/patient ratio (particularly that of medically-qualified staff) is exceptionally high by comparison with most psychiatric hospitals in the United Kingdom.

Tentative steps had been taken in 1971 towards a process of 'sectorisation' - that is to say, association of each of the admitting teams with a particular sector of the hospital's catchment area. The object of this arrangement is to facilitate closer relationships and collaboration between the hospital and the primary health care and social welfare agencies serving each area. At the time of this study only limited progress had been made in creating territorial

bases for the work of clinical teams; each team was still treating patients from all parts of the hospital's catchment area. (It is understood that since then substantial progress has been made with sectorisation).

The community psychiatric nursing service of the Royal Edinburgh Hospital was initiated on a small scale in 1969. It was associated with continued efforts within the hospital to rehabilitate and reestablish in the community some of the long-stay population of patients. Its inception also coincided with the reorganisation of local authority social services in Scotland on a generic basis and the discontinuance of specialised mental health social welfare services by the local health authorities. The original function of the service was concerned with discharge and after-care; the role of the hospital-based psychiatric nurse in community care was defined in the context of this service as follows (Nickerson 1972):

> "To give a service which covers protective care and after-care of those who require encouragement and support to become fully integrated into the community".

The service acquired a recognized function in selecting and supervising appropriate residential accommodation for patients who could not be discharged to their own homes, and developed links with a number of institutions, boarding-houses and private landladies. The service also helped to place patients in employment, set up liaison with social clubs for the mentally disabled, and assisted with psychiatric emergencies and compulsory admissions (Nickerson 1972).

In April 1972, when the collection of data in this study was begun, the staff of the service consisted of five registered mental nurses graded as staff nurse or charge nurse. The five field-workers were under the leadership of a nursing officer who did not at the time take a direct part in the care of patients in the community but had a general supervisory and counselling role. The nursing officer was also responsible for the nursing administration of the hospital's rehabilitative hostels. Each of the five community psychiatric nurses was assigned to one of the five admitting clinical teams; some members were attached in addition to clinical teams having responsibility for long-term wards and day-care facilities within the hospital. The degree of involvement of community psychiatric nurses

with their teams varied from an extensive commitment to the team's ward-based activities to a peripheral position of 'availability on demand'. The writer's observations suggested that the roles played by the community psychiatric nurses in relation to the teams varied as widely as did the teams themselves in composition, structure and function. In this study no attempt was made to analyse the relationship between the nurse's function and her position in the team; the two were certainly connected, and this is an area which would probably repay closer study.

There was a certain amount of specialisation of function between members of the community psychiatric nursing service on the basis of personal contacts and relationships with institutions outside the hospital. There was also some difference between the work of men and women; the two male nurses for instance were more likely than the women to undertake escort duties in connection with compulsory admissions to hospital. Differences based on staff grading were minimal.

None of the members of the community psychiatric nursing service had undergone specific training for this working situation. The experience of individuals in psychiatric nursing before their appointment to the service ranged from 3 to 17 years, including formal training. Most in addition had training or experience in general nursing. All had previously worked in other fields or had brought up a family. The main methods of orientation to the community working situation which had been used were observation of other members of the service at work and discussions with colleagues in the service itself and with clinical team members. All members had been able to attend occasional study days, residential conferences and visits to other centres which were relevant to the provision of care in the community.

In this report, individual community psychiatric nurses are always referred to as 'she'. This convention has been adopted for simplicity's sake, although there were both men and women in the group of nurses studied. Similarily, patients are always referred to as 'he'.

The attitudes of members of the group towards research activities in general, and this study in particular, ranged from interest to unconcealed antipathy. Previous studies of psychiatric nursing undertaken in the same hospital had been experienced by some members of the nursing staff as a threatening process of appraisal which produced (in

their opinion) inaccurate and unjustifiably critical conclusions. This impression had lingered and had been transmitted to staff of more recent standing. Moreover the introduction of the project and the research worker to the staff to the service was not sufficiently considered and planned.

The problems of initiating research in complex organisations have been discussed by Kahn and Mann (1952) who stress that the research worker's relations with the authority structure must be carefully managed. Acceptance from "top levels" of the structure is generally required, but communication from this level "has overtones of command for those at lower levels and is responded to accordingly. Since the researcher requires spontaneity and cooperation rather than docility and obedience, it is not enough ..... to use the ready-made authority structure". These authors recommend a series of negotiations of "contingent acceptance" at successively lower levels in the hierarchy.

By the time the research worker arrived upon the Edinburgh scene, a grant for the project had been secured and her own appointment had been finalized. Not surprisingly, the community psychiatric nurses felt that they had been presented with a fait accompli, and to begin with they felt that the researcher had been appointed to assess the quality of their work. The need for the study could not be made apparent to some members who felt that the functions of the service could easily be discovered by a simple process of question and answer. Although assurances were given that participation in the study was voluntary, the writer has little doubt that members did not feel entirely free to opt out of a project which was sponsored by the 'top brass' of the hospital. These problems created a climate of reserve which persisted to some extent throughout the study.

In these circumstances it is pleasant to recall the openness and magnanimity with which the whole issue was discussed, and the generosity of the nurses' decision to shelve their doubts and to participate in the study.

It is probable nevertheless that their reservations about the study are reflected in some way in the quality and amplitude of the information obtained. The effect may not have been wholly negative. The fact that nurses were urged to consider the completion of data

schedules as 'part of the job' may have enhanced the accuracy and consistency of the records.

Even had these pitfalls been avoided, and had the project been launched with the utmost skill and care, it seemed probable that considerable resistance would still have arisen from two sources. The first was the ill-defined position and functions of the community psychiatric nurse which saps her confidence in the appropriateness and legitimacy of her own activities. The second will be familiar to many researchers in nursing contexts, and is related to anti-intellectual attitudes and suspicion of academic methods and pursuits (Bendall 1973; Copp, 1975). It is possible that without the influence of the authority structure the study could not have been undertaken in this setting.

SECTION 3: SOME RELEVANT LITERATURE AND ITS APPLICATION TO THE STUDY.

3.1 The concept of 'Community Care'.

The place of psychiatric nurses in 'community care' must depend upon how 'the community' is defined. The phrase 'community care' has become something of a slogan used without precision and in different senses in varying contexts. When the community care idea was in its heyday, Titmuss commented that it was characteristic of the English to be confused or misled by an idealistic description of a policy into believing that it already corresponded with reality; "what some hope will one day exist is suddenly thought by many to exist already" (Titmuss 1961). More recently, Arie (1972) has suggested that the "semantic plasticity" of the concept, and its place in current caring ideologies, deserve study in their own right. An extended discussion of the 'community care' idea would be out of place here, but the interpretations attached to it and the concepts of mental disturbance and psychiatric treatment to which they are related must be mentioned, because they afford bases for widely different formulations of the principles and practice of psychiatric nursing in 'community' situations.

The Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1957) has been described (DHSS 1975) as the "watershed" for the adoption of the community care idea in Britain. Titmuss noted that the phrase had already been adopted by the Ministry of Health in 1950 to describe the mental health social work services of local health authorities, but could not trace a more precise origin for the term. The Royal Commission's recommendations were based upon two principles - the definition of mental disturbance as sickness, and therefore of mental treatment as a province of medicine; and the separation of medical from social forms of care. The Report emphasised the treatment function of mental hospitals, which were only to provide services for people who needed specialist medical treatment or continuous nursing care. It approved the increasing accessibility and informality of psychiatric treatment. Psychiatric illness should not be regarded as in any way different from any other kind of illness; therefore people in this category of need should have equal access to the general social services provided by central and

local government. The asylum functions of the mental hospitals and other specialised supporting services for the less severely disabled should be transferred to the category of 'community care'. Local authorities were already responsible (under the National Health Service Act of 1946) for the care and after-care of mental patients living outside hospitals, and (under the National Assistance Act of 1948) for providing residential accommodation for persons in need of care and attention. They had, in addition, powers to provide other preventive and caring services for handicapped and disabled people. The Report noted that since 1948 there had been some confusion of responsibilities between hospital and local authorities, and that some hospital authorities were providing services which properly should belong to the local authorities. It recommended a shift of emphasis from hospital to 'community care', away from existing forms of institutional care and towards a range of residential and other facilities 'in the community'. Local authorities should provide, in cooperation with the hospital services, residential care, preventive services, vocational and industrial rehabilitation and training, sheltered employment, day centres for the aged, social help and domiciliary advice.

The new policies for the mentally disturbed were given legislative effect by the Mental Health Acts of 1959 and (for Scotland) 1960. Proposals for translating them into administrative action (in terms of expenditure on hospital structures and on local authority buildings and services) were published by the Ministry of Health in 1962 and 1963. Plans for increasing the number of trained social workers who would be required to operate expanded programmes of 'community care' had already been put forward by the Younghusband Committee in 1959.

The Hospital Plan for England and Wales (Ministry of Health 1962) envisaged the 'run-down' and eventual closure of most of the existing mental hospitals. It was proposed that the care of adult psychiatric patients should be re-allocated between new short-stay psychiatric units in district general hospitals and 'community care' facilities provided by local authorities. The care of the aged and demented population was to be dealt with separately, again on a basis of coordinated action by the hospital and social services. Doubts

were however almost immediately expressed about the capacity and willingness of local authorities to undertake extensive new responsibilities; Titmuss estimated (1961) that expenditure per head on 'community care' for the mentally ill had actually decreased since 1951.

In Scotland changes in policy have been more cautious. The Hospital Plan for Scotland (1962) envisaged change towards care 'in the community' for some classes of patient; but it was recognised that hospital facilities were interdependent with local authority and general practitioner services, and that the changes would depend on the development of extra-hospital facilities (Department of Health for Scotland 1962). The Scottish mental hospitals, which are generally smaller and more conveniently situated than their English counterparts, are not to be 'run down', but may change their functions. Resident populations of Scottish mental hospitals have been declining since 1958, and there has been some redistribution of functions between hospitals and 'community care' agencies; but there is very little published documentation of the process (Baldwin 1971).

The ideal of 'community care' found general acceptance among psychiatric professionals; indeed "to oppose it was reactionary if not sacrilegious" (BMJ 1974). The British literature is largely pragmatic rather than theoretical in approach, drawing basic concepts from the relevant American literature in the fields of sociology and social psychology. Any selection from the numerous articles and reviews on the implementation of the 'community care' idea in Britain would show the ambiguity of the phrase and the variety of ways in which the idea is interpreted and justified. The term is indiscriminately used to denote either a principle of administration or the actual range of services provided. Similarly 'the community' is used to denote both a social group and a territory. The concept of community care is interpreted in three ways:

(i) Community care means care of social problems by social agencies

This interpretation is derived directly from the conceptual distinction between social and medical problems drawn by the Royal Commission, whose view of 'community' and 'hospital' care was essentially antithetical This usage excludes

from the domain of 'community care' both the primary medical services and specialised facilities including all forms of hospital care. It is often used in an even more specific sense to denote the responsibilities of local authorities for the provision of services (Titmuss 1961, Harrison 1973).

(ii) Community care means any form of care or treatment given without admission to a mental hospital (including care offered by medical or psychiatric agencies)

This view arises from the reaction against traditional mental hospitals, the stigma and social segregation associated with the institution and with inmates' characteristic adaptations to its social organisation. Provision is at one of two poles: the traditional custodial institution (bad) versus integrated, non-specific 'community' facilities (good). The work of Goffman (1961) and of Barton in this country (1959) showed some of the harmful aspects of institutional care. 'Integrated' facilities were championed by the proponents of the balanced hospital (McKeown 1958) and of general hospital psychiatry (Rohde and Sargant 1961). This is essentially the official view embodied in Government policy for 'mental health' services since 1959.

(iii) Community care means a comprehensive system of preventive psychiatry.

This interpretation, which was characteristic of the aspirations of the community mental health movement in the United States of America, is particularly influenced by Caplan's formulation of the aims of comprehensive psychiatry (Caplan 1961). His definition of community mental health activities was "the processes involved in raising the level of mental health among the people in a community, and in reducing the numbers of those suffering from mental disorders". Caplan's threefold classification of preventive functions is now generally applied to all spheres of preventive health care:

> "Primary Prevention .... the processes involved in reducing the risk that people in the community will fall ill with mental disorders ...
> Secondary Prevention ... the activities involved in reducing the duration of established cases of mental disorder and thus reducing their prevalence in the community ...
> Tertiary Prevention ... the prevention of defect and crippling among the members of a community .... rehabilitation services which aim at returning sick people as soon as possible to a maximum degree of effectiveness". (Caplan 1961 p. vii).

Caplan's public health analogy implies that 'community care' should be concerned as much with groups or populations as with individuals (Roberts 1966). Sabshin (1966) and Roberts (ibid.) define a community as a specified population linked together by common geographical boundaries or a common function or activity. The preventive ideology requires the acceptance of responsibilities extending beyond the normal range of clinical functions to quasi-political community action (Bellak 1964). American writers have expressed doubts about whether it is feasible, at the present time, to introduce preventive methods in psychiatry applicable to groups or populations, given that current knowledge of aetiological factors is incomplete (Whittington 1965), and that professional training and practice in psychiatry are generally focussed on the individual 'patient' (Pasewark and Rardin 1971). Baldwin (1971) explained the orientation of the American community mental health movement towards case-finding and prevention by reference to the structure of American medical care which offers no generally available means of assessment and referral such as is provided in Britain by the general practitioner service. Although American structures and experience in the community mental health movement have been very different from our own, many of the ideas which inspired it have been very influential in this country.

The underlying principles on which systems of care are based seem seldom to be made explicit in the British literature. This is unfortunate since divergent positions and arguments may not be recognised. The two main types of argument are in terms of environmental influences on the individual, and of his moral and

political rights.

In one of the few systematic attempts to formulate a 'rationale' for community care, Susser (1965) uses concepts of social role, drawing particularly upon Parsons' exposition of the 'sick role' (Parsons 1952). Becoming a hospital patient positively encourages the individual to abandon normal roles and responsibilities in relation to his family and community; whereas treatment which avoids incarceration in hospital promotes the maintenance or resumption of socially functional roles. Treatment in the 'normal' environment is desirable, also, because theories of institutionalism enable one to predict that the hospital environment will itself produce adverse effects upon the behaviour of the individual. Another view, that of mental disturbance as a manifestation of pathological interaction within a social group (usually the family) leads to the definition of the patient as scapegoat and of the family as patient. In this context treatment can only be valid if it embraces the family or social group in which the disturbance originated (Kahn 1963). Moreover it is necessary to observe the patient in relation to many aspects of his social world in order to obtain an adequate frame of reference for understanding the patient's experience (Susser 1965, May 1965).

The second main line of argument suggests that the definition of a person as mentally ill is essentially a social response to socially unacceptable behaviour (Scheff 1966). The psychiatric 'label' is not necessarily related to any biological abnormality, but its effect is to attract social stigma and social rejection which themselves engender deviant behaviour. It is unnecessary to consider the more extreme variants of this school of thought since the holders would not consider any form of care within the present framework as a solution to the problems of disturbed behaviour. More moderate versions emphasise the individual's right to a place in the community (considered as a social group), and the community's duty to provide for its dependent members (e.g. Denham 1965).

A formulation attributed to Querido seems to include both of these lines of thought. Community care is described as:

> "a logical development of the concept that mental illness could only be comprehended as a loss of equilibrium between the patient and his environment. He is part of a dynamic pattern

> of disturbed human relations; consequently the re-establishment of the patient consists ultimately in the re-establishment of these relations; and this is a process that can only be brought into play in the community itself". (McDowall 1973 p.90)

The principles of 'community care' have been the subject of continuing debate. The assumption that care 'in the community' was always in principle superior to care in a psychiatric hospital was questioned (Jones and Sidebotham 1962). A system of care should be judged not by its location or sources but by its attributes; and the qualities required in the care of the mentally disturbed were diversity, flexibility, adequacy and the capacity to facilitate social relationships (Jones 1964). The discontinuities inherent in separate systems of social and psychiatric care were observed to militate against patients' interests: first, hospital staff tended to neglect "all-important social factors", to see the patient in clinical terms as a case for treatment and cure, and to apply standards of assessment appropriate to the sheltered environment of the hospital but not valid in terms of normal social requirements. Secondly, administrative divisions led to transfers of responsibility without proper consultation or preparation. Thirdly professional staff 'in the community' (both medical and social) lacked sufficient specialist support and were prone to value-laden and rejecting attitudes to the disturbed person (May 1965). More recently Wing and Brown (1970) have described social factors which affect the symptoms and behaviour of schizophrenic patients and which may operate either inside or outside hospital. These writers believe that the skills and traditions of rehabilitative work developed by mental hospital staff are relevant to the new problems of community psychiatry but, because of the separation of clinical from social care, they are in danger of being lost (Wing and Brown 1970 p. 193). In a related field Jones and her co-workers (1975) have noted the inappropriateness for mentally subnormal people of making separate provision for 'medical' and 'social' needs. This is due, they suggest, to thinking in terms of available resources rather than about what the patients themselves require. "We have to attempt to free our minds from the constraints of what we have" (Jones et al. 1975 p.193).

In the last few years the focus of interest has shifted from the concept of 'community care' to that of a 'comprehensive psychiatric

service '. The original formulation of this idea is due to Caplan (1961), who described the components of "an ideal pattern of a comprehensive programme" which was to be patient-focussed, not limited by institutional boundaries, easily accessible and rapidly responsive; which would pay attention to the effects of inter-personal and social environments and avoid detaching patients from them; and which would be characterised by free communication and continuity of care. The application of these principles to the planning of comprehensive services was elaborated at a series of discussions sponsored by the World Health Organization. A particularly full discussion of the issues is found in the report of a Working Party (WHO 1972) which laid stress on the need for consensus between the service and 'the community' on the former's proper role; for adequate assessment and understanding of environmental and social factors in the genesis of mental disorders; for a multi-disciplinary approach to treatment and care which should pay regard to psycho-social as well as medical measures.

Experiments in developing comprehensive services (in which nurses played a part which will be discussed below) began in Britain at Nottingham during the 1940s (Macmillan 1963), and in Croydon, Plymouth and elsewhere some twenty years later (May and Wright 1967, Weeks 1965). "With the evolution of psychiatric practice the specialized hospital for the mentally ill is increasingly seen as part of a comprehensive community mental health service." (Tripartite Committee 1972). The proposed reorganization of the National Health and local social services gave an impetus to discussions about the coordination of the new services (Cawley and McLachlan, 1973, DHSS 1974a). Official policy has now been reformulated in the White Paper 'Better services for the Mentally Ill' (Cmnd 6233, DHSS 1975), which denies that "the failures and problems of the last 20 years render invalid the concept of community oriented care and treatment" and affirms the Government's belief in "the philosophy of integration rather than isolation". Adhering to the policy of separate generic medical and social services, the White Paper sets four broad objectives: an expansion of social services provision; relocation of specialist psychiatric services in local settings; organizational links between the component parts of the service; and improvement in staffing levels to enable multidisciplinary work to be done, and to provide

for early intervention and preventive work. The answer to problems of "fragmentation and selectivity" is to be through "team-work" and the building up of close relationships between staffs.

What place should the psychiatric nurse occupy in 'community care' as interpreted in the three different ways which have been outlined? In a system where medical and social care are provided by separate, un-integrated services, the nurse would retain her central position in the social organization of the psychiatric hospital, but in the community setting would become merely a medical auxiliary worker, administering treatments and monitoring their effects, while all the psycho-social aspects of the nurse's role in hospital would be assumed by the social services in the community. If the object of a 'community care' service is to dispense with treatment in psychiatric hospitals, then the psychiatric nurse's function in the community is to provide alternatives or substitutes for hospital forms of care. In an integrated system of comprehensive psychiatric services, the psychiatric nurse's function in the community is not to act as a substitute for hospital care (which will be part of the range of services available), but to give whatever level and type of nursing care and attention is needed at any given stage by the patient and his family at home. The nurse's care (as suggested by Caplan's definition) will be patient-focussed; its continuity will not be interupted by institutional boundaries; it will be accessible and responsive; and it will pay regard to social and interpersonal factors as well as to clinical aspects of care and treatment.

Until the divergent conceptions of 'community care' in psychiatry have been recognised and a common approach has been evolved, it is inevitable that there will be uncertainty and confusion about the contribution, not only of community psychiatric nurses, but also of all the other health and social services. In the meantime, each of the above interpretations of the community psychiatric nurse's role is likely to be applied simultaneously by one or other of the colleagues to whom the nurse is clinically and administratively responsible. Nurses themselves may swing from one conception to another without being aware of the inconsistency in their own position. Examples of such inconsistencies and contradictions may be found in the statements of nurses and doctors about the functions of the service (sections 10,

11, 12). These ambiguities may be expected to introduce strain, misunderstanding and conflict into the working relationships of the community psychiatric nurse with her own and other disciplines.

3.2 Interdisciplinary relationships in the community situation

The literature on the sociology of institutions and the social psychology of group behaviour gives some indications about the kind of problems likely to arise between members of different disciplines in the changing situation of psychiatric services in the community.

The concept of social role referred to in this discussion relates to the behaviour which is expected of occupants of a particular 'position' or 'status' in society by themselves and others. Social roles have been defined as

> "the expectations of behaviour which are associated with individuals as occupants of specified social locations. These expectations are perceptual and ... are conveyed to the occupant of a position by members of his role set in the form of approval and rewards for playing his role as expected or as disapproval, rejection or punishment if role expectations are violated". (Hunt 1974, p. 78)

Mechanic (1968) discussed the usefulness and the shortcomings of the concept of social role as an analytic tool. According to the structuralist formulation of the concept, the individual's performance in his roles is predetermined, and his rights and obligations by virtue of his role are prescribed by social forces over which he has no influence. The abandonment of individual autonomy which this view implies has been criticised, and Mechanic cites varies elaborations of the basic concept - role strain, role distance and others - which he regards as somewhat ineffective efforts to solve the problem of deterministic conceptions of role (cf. Wrong 1961). Hunt gives an excellent summary of the relevant literature on 'role theory' in the context of her study of work relationships in community health services settings. Hunt looks at roles primarily as stable features of the social structure. She discusses the sanctions by which role expectations are enforced on individuals by society, but gives less prominence to the processes by which roles come to be defined in society and enacted by the individual. She concludes however that "if members of a group interact for any

length of time, role differentation becomes stabilized and a set of norms become established." Rushing (1964, pp 5-14) criticised the structuralist position, which he considered inappropriate to situations in which role relationships are not highly 'institutionalised' (i.e. well established on the basis of mutual agreement between the parties concerned). In the context of his own study of power relations among the staff of a psychiatric hospital, Rushing found "a lack of clarity in role definitions among mental health professions" (p.8). Accordingly he adopted an interactionist perspective on role-making and role-taking through processes of negotiation, influence, reward and deprivation. Rushing explains how the concept of the reference-group may be used to show how these processes work; normative reference groups provide the individual with social norms which are assimilated as attitudes and which influence his definition of his role; evaluative reference groups are sources of 'expressive' rewards such as appreciation, recognition and respect; comparative reference groups allow the individual to assess the rewards he receives by comparison with those of others.

In situations of technological and social change the division of labour within and between occupational groups is likely to change; and where roles and role relationships are relatively unstable, conflict between the groups concerned is likely (Hughes 1960). Blau and Scott (1963 p. 100) state that conflicts between working groups are particularly likely to arise from changes which affect established status relationships. Vollmer and Mills consider that differentiation of functions is a crucial factor (1966, p. 227):

> "Where an occupation's function supplements or complements the work activities of other occupations, problems of inter-occupational relations may be minimized. But where there is duplication or some degree of overlap among occupations, then problems often arise".

Another writer maintains that conflict relationships are most likely to occur when similar work tasks are being performed by people of widely differing training and status (Weber 1957). Conflict need not however be regarded as necessarily dysfunctional

since it may act as a stimulant of innovation and development (Bennis et al. 1970).

A further source of conflict is found in differing interests and value orientations - for example when the professional worker's characteristic concern for the interests of the client are opposed to a more bureaucratic insistence on the needs of the organization (Blau and Scott 1963 p. 174). Similarly, Weber noted that conflict results when groups of workers of unequal status hold differing values regarding their own and others' work, and divergent ideas of their statuses and roles (Weber 1957).

Conflict does not necessarily manifest itself openly. It has been observed (for instance by Stanton and Schwartz 1954) that unacknowledged and unresolved disagreement between staff in a psychiatric hospital ward may be reflected by disturbed behaviour among the patients. Coser (1956) holds that the expression of conflict is only tolerable when there is a degree of stability in existing relationships. Avoidance tactics are often reported as a method of responding to latent conflict (Burns and Stalker 1961 p. 151; Vollmer and Mills 1966 p. 243), and were acknowledged by members of nursing staffs in Hunt's recent study of 'teamwork' in general medical practice (Hunt 1974 p, 213).

Conflict within the nursing role itself can arise from the current drive towards professionalization. Nurses' demands to be accorded professional status imply a claim of professional autonomy, the duty to give prime consideration always to the interests of the client, and acceptance of discipline only through "self-imposed standards and peer-group surveillance" (Blau and Scott 1963 pp.61-63). These aspirations are at variance with the bureaucratic system of accountability through a hierarchy of authority introduced on the recommendation of the 'Salmon Committee ' (Ministry of Health and SHHD: Committee on Senior Nursing Staff Structure 1966). Nurses' claims to professional autonomy are dismissed as illusory (Dingwall 1974) on the ground that in the community setting (with the partial exception of Health Visitors) nurses' access to patients is controlled by medical practitioners (see also Hockey 1966 p. 17). This factor gives the expectations of the medical profession a powerful influence over nurses' performance.

Findings from a number of studies tend to support the suggestion that nurses' interpretation of their role is highly dependent on the setting in which they work, and particularly upon the attitudes prevailing among their medical colleagues. Rushing suggests (1964, p. 117) that the psychiatric nurse's role contains an inherent element of potential conflict between "the obligation to help the patient and the responsibility to carry out the resident's* orders ... Such conflicts are especially likely when the nurse-patient relationship is emphasised as an aspect of the treatment process." Other work suggests that nurses may minimize such conflicts by accommodating their own ideas to those held by the medical staff with whom they are most in contact. In an American study specifically concerned with ideologies of psychiatric treatment, Strauss and his co-workers (1964) found that nurses were inclined to endorse whatever ideology (psychotherapeutic, somatotherapeutic or sociotherapeutic) was dominant among their medical colleagues, and that as an occupational group they showed no attachment to any particular set of ideas. A recent British study (Towell 1975) has shown that the perspectives adopted by nurses for the understanding and interpretation of their functions are radically modified by the setting in which they work. Towell concludes that the label 'psychiatric nurse' "encompassed a cluster of different roles, varying quite radically according to the setting in which these were performed." (p.204). In another British study, Caine and Smail (1967, 1968) showed that variations in nurses' attitudes to some aspects of psychiatric treatment were associated with different working environments.

Rushing studied the institutionalization of roles of members of psychiatric professions in an American teaching hospital. Rushing argued from his observations that holders of roles which are not well institutionalized will incur relatively high 'costs' in terms of personal inconvenience and effort in order to make their concept of their role known and accepted by those other professionals who constitute their reference groups ; whereas in cases where roles are relatively highly 'institutionalized', modes of interaction are directed towards the reduction or elimination of such costs.

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* A 'resident' is roughly equivalent to a registrar in psychiatry in British parlance.

Rushing seems at times to be offering as evidence in support of his hypothesis the same observations as those from which the hypothesis were developed, so that his conclusions must be regarded as speculative.

Turning from these rather theoretical considerations towards more empirical studies, there were two investigations of 'community care' in Britain in the 1960s which should be mentioned both for their intrinsic importance and for their influence on the methods of the present study. These were Jefferys' survey (1965) of the work of welfare services in an English county, and the study carried out in the early 1960s by Rehin and Martin (1968) of some aspects of community mental health services in four areas of England. These authors studied many aspects of professional services through the reports of workers about their transactions with, or on behalf of, their clients, and derived representative samples of the caseloads of services from the workers' records of the cases which they saw during particular periods.

These two surveys of community services in action revealed some of the problems of coordinating functions and defining roles in the community setting. Jefferys' influential study (1965) of the work of personal and domiciliary welfare services covered not only those agencies conventionally regarded as engaged in 'social work', but also the welfare aspects of the work of (among others) medical practitioners and community nursing staff. Jefferys studied the various types of worker, their levels of training and some of their personal characteristics, and their functions in relation to their clients. Some of her conclusions related to problems observed in the relationships between health and welfare services, and in the deployment of staff.* There was "considerable strain" in the relations between general practitioners and health visitors and it was noted that

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* Jefferys' proposed solutions to these problems have largely been implemented in subsequent changes in the organization of health and social services - notably in the institution of 'generic' social work services, based in local authority departments to which hospital social work staff have now been transferred; and by efforts to foster the development of 'primary health care teams' including the attachment of health visitors to general medical practices and the location of social workers at health centres.

general practitioners were often unaware of the range of social services which could assist their patients. Jefferys compared the work situations of hospital-and local authority-based social workers, and concluded that the domiciliary work situation demanded more in terms of independent judgment, skill and initiative in difficult circumstances. It was paradoxical therefore that the more highly educated and trained social workers were generally employed in hospital situations where opportunities for autonomous work were on the whole more limited.

Similar conclusions were reached by Rehin and Martin (1968). These investigators compiled quantitative data about patterns of utilization of mental health services in four different areas and descriptive material about the work and aims of mental welfare officers* in five areas, and derived comparisons from these. They found differences in the 'ideologies' of mental welfare work expressed by mental welfare officers in different areas, and suggested (p.232) that these differences should be attributed to influences exerted through contact with other professional groups. Three 'images' of the mental welfare officer were distinguished: an intermediary worker in an illness-treatment-resettlement process; a social caseworker in a direct, instrumentally-helping or therapeutic relationship with the client; a traditional welfare officer advising, informing and supporting the client (p.182). Rehin and Martin found, however, that their categories were not mutually exclusive - for instance it was "difficult to distinguish between aspects of social care in the community or between stages of the illness-treatment process" because 'after-care' to one worker may be 'social support' to another. "Definitions of function may have been affected by relationships among the different services" (ibid. p.171). The authors entered a caveat about the interpretation of the data on the perception of problems and the description of activities, pointing out that differences could be purely semantic

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* The majority of mental welfare officers were not professionally qualified in social work (Rehin and Martin 1968 p. 191), and most of them are said to have been recruited from psychiatric nursing (Cawley and McLachlan 1973 p. 172). Mental health social work has ceased to be a separate category of practice since the introduction of 'generic' departments.

or ideological while the actual exercise of function could have been more or less identical (p.231). In the present study, similar problems arise in the interpretation of data derived from individuals' descriptions of their own aims and activities (vide sections 9 and 12).

'Community care' was defined by these authors as consisting ideally of "an inter-communication process in a network of services in which the client (or patient) was in an appropriate relationship with an appropriate helper (psychiatrist, general practitioner, social worker, nurse etc.) at the appropriate stage of his illness. This process was conceived as requiring the passing of information from helper to helper by referral (e.g. for after-care), continuous liaison, case conferences, consultations and the like" (Rehin and Martin 1968, p.173). The operational analyses showed a variety of rather more restricted patterns of communication between mental welfare officers and other related services, which suggested that the former were not operating in accordance with the ideal model of community care. "Foci" or targets of liaison activities varied considerably from area to area, in some cases being mainly directed to general medical and community services, and in others towards psychiatric hospital services and internally to other members of the mental welfare department.

Brook and Cooper (1975) have recently reviewed the British literature on the provision of 'mental health care' by 'primary health care teams' and specialist psychiatric services. They see a need for closer working links between primary and specialist services, and scope for experimentation in the structure and functioning of these services. In both connections more information and operational studies are required about the functions of the different professional groups. These authors describe a variety of functions undertaken by psychiatric nurses in the community, but express the view that it is more important to maintain the quality of in-patient psychiatric care than to establish psychiatric nursing services in the community. They note that information about the number and distribution of community psychiatric nurses is conspicuously lacking.

The material which has been reviewed suggests that when nurses change the setting of their work from the hospital to the domiciliary situation, their definition of their functions, attitudes to their

work and ideological positions may undergo a substantial change. This change will arise partly from a change in the perspective from which they see their patients. The need for the nurse to maintain routine, order and control in the institutional setting will be displaced by the need to assess the pressure on the patient to conform with variable standards of social acceptability (depending on his environment). For the nurse, a degree of identification with the needs of an institutional regime is likely to give place to an alignment with the patient and his family. In so far as the nurse has more contact with other community-based workers than with hospital nurses, she may also adopt perspectives and attitudes more like the former and less like the latter.

Nursing staff working in the community have traditionally had access to new work through referral by doctors or through medical structures. The influence of the medical profession on the role and functions of such nurses has been very great. Community psychiatric nurses are likely to be similarly influenced if their access to cases is controlled by medical staff. (See section 7 for information on referral processes).

Problems of conflict are likely to arise in the community situation to the extent that the functions of nurses and of other related professional groups overlap or are not clearly delimited, particularly if their respective roles or their mutual statuses are uncertain or unstable. Exploration of interdisciplinary role relationships was not among the objectives of this study; but the potential difficulties from this source may be borne in mind in connection with the nurses' account of their aims and methods (section 12), and with data on nurses' activities.

Serious conflict between doctors and nurses is unlikely so long as existing status distinctions remain unchallenged, and values and perspectives derived from their common clinical background are shared. As their role relationships are relatively stable and well-defined, a degree of overlap in functions (already accepted without question in many contexts) is likely to be easily tolerated also in the practice of community psychiatry. (The views of psychiatrists and general practitioners are discussed in sections 10 and 11).

In relation to other nursing staff in the community, some problems might be expected. Although status relationships are fixed and many value orientations are likely to be compatible, some areas of functioning (e.g. physical treatments for psychiatric conditions; counselling the families of the chronically disabled; care of mixed physical and psychiatric syndromes in the elderly) are liable to overlap.

The greatest uncertainty and potential conflict should in theory arise in relation to the functions of social workers. A multiplicity of factors may operate simultaneously. Firstly, community psychiatric nurses may be considered to encroach on what is by definition an area of social work inasmuch as they are exercising some of the functions which mental welfare officers fulfilled in the past. (It might however be relevant to consider how far these officers were in practice using nursing skills). Secondly, nurses and social workers are likely to hold divergent views about the nature of and appropriate responses to psychiatric disorder, especially since the so-called 'medical model' of mental illness is repugnant to many social workers. Thirdly, the interpersonal aspects of the psychiatric nurse's work are not clearly differentiated from the counselling and casework functions of the social worker. The extent of the identity or interchangeability of these skills has not been defined, nor have appropriate areas for their application been agreed between nurses and social workers. Fourthly the relative status of the two occupations is unstable owing to professionalisation in nursing, bureaucratisation of both careers, the virtual disappearance from the field of the University-educated, analytically-oriented psychiatric social worker, and the substitution of the vocationally-trained 'generic' social worker. (This area was not specifically explored in the study; little evidence of actual conflict in fact came to light.)

Some attempts have been made by social workers themselves to arrive at a satisfactory differentiation of nursing and social work roles; these will be mentioned in connection with the descriptive and prescriptive literature on the role of the community psychiatric nurse.

Other influences which help to determine the community psychiatric nurse's performance of her functions are:-

(i) the characteristics and needs of the nurse's clientele

(ii) the ideological positions or perspectives from which psychiatric disorder and treatment methods may be understood

(iii) the functions of the psychiatric nurse as the nurse has learned to understand them

It is only possible to mention briefly the extensive literature in these areas.

3.3 Psychiatric patients in the community

Most forms of psychiatric illness have social correlates, and these are obviously of greater significance in the community situation than in hospital nursing. People suffering from psychiatric disorders tend to experience all sorts of social difficulties; whether these difficulties are related to the disorder as cause or effect is usually not clear, but in some cases (as in some psychopathic disorders) the social difficulty itself constitutes the disorder.

The majority of studies of psychiatric patients and their families in the community have related specifically to schizophrenic disorders, presumably because these create by far the most important group in terms of chronicity and severity; but it has been shown that, even taking people suffering from 'minor' psychiatric disorders (predominantly depressive and anxiety reactions), there is a strong positive association with various forms of social dysfunction in major aspects of everyday life - viz:- housing, finances, occupation, social contacts and leisure activities, personal interaction and parenthood (Cooper 1972).

Studies of schizophrenic patients and their families are numerous. Much of the best work in Britain has emanated from the Medical Research Council's Social Psychiatry Research Unit in South London. This work has been reviewed in greater detail by Wing (1973, pp 157-160) and Kennedy (1975). American work on schizophrenia may not always be strictly comparable because of the different criteria in use in the U.S.A. for diagnosing these conditions.

A lack of capacity to make normal social relationships appears in many studies of schizophrenic patients. A high degree of withdrawal from social activity and contact is common, and this tendency to isolation holds true for people at home (Creer 1975). Schizophrenics, especially men, more often remain single than 'normal' people (Forrest and Affleck 1975). Schizophrenics are particularly vulnerable to aspects of their living environment. It has shown than an under-stimulating environment leads to 'negative' impairments of social performance - withdrawal, flatness of emotional

response, slowness and underactivity (Wing and Brown 1970). Too many demands which are emotionally stressful for the patient - for instance unduly vigorous attempts at rehabilitation, or discharge to a home where criticism or other emotional attitudes are freely expressed - are likely to lead to relapse to more florid symptoms (Brown et al. 1962, 1972). Although many families are highly tolerant, discharged patients tend to do better away from their parental or conjugal homes (Brown et al. 1958). The family home may resemble a "one-person chronic ward" (Freeman and Simmons 1958), and may be a less favourable environment for the chronically disabled schizophrenic patient than a well-run hospital ward, which provides the required level of tolerant support and consistent but unemotional pressure towards socially acceptable behaviour. Schizophrenic patients often lose their footing in their families through hospitalization or their tendency to drift into isolated situations. Unduly high proportions of schizophrenics have been found living in deprived inner-city areas (Faris and Dunham 1939) and in common lodging-houses and hostels (Priest 1971) where they tend to do badly (Brown et al. 1958).

The contention of Bateson, Wynne, Lidz and others that schizophrenia is causally related to abnormal forms of communication between the child and its parents should be mentioned. The evidence has been reviewed recently by Hirsch and Leff (1975), who found some evidence of abnormal attitudes and relationships in the parents of schizophrenic patients towards each other and towards the pre-schizophrenic child. The available data is however not sufficient to show whether these abnormalities are causally related to the disorder, or whether they may be the effect of some shared genetic predisposition, or of latent disorder in the child's capacity to communicate. Hirsch and Leff attempted to replicate some of Singer and Wynne's experimental observations but were not entirely successful.

Work is generally looked on as one of the chief means of rehabilitation and reintegration in the general life of society for ex-psychiatric patients (the other being domestic resettlement - Early 1965). Return to work is generally synonymous with recovery from symptoms in people suffering from conditions other than

schizophrenia (Goldberg 1966). For many schizophrenic patients, work is their main opportunity for contact with other people; but their work record is often poor (Brown et al. 1966 p.77). For schizophrenics, a consistent work record does not necessarily imply freedom from symptoms or vice versa (Wing et al. 1964, Goldberg 1966). Schizophrenic women appear to function more competently as housewives than in employment (Brown et al. 1966, p. 83). Capacity to work in schizophrenics tends to be limited to jobs of low status and poor remuneration often below the social level of their parents' occupations (Goldberg and Morrison 1963).

It has been shown that drug treatment helps schizophrenic patients to survive in the community (Renton et al. 1963) and to be regular in work performance (Esser et al. 1965). Parkes and his co-workers (1962) estimated that oral tranquillizers were not taken as prescribed during about 50% of the periods covered, and found that treatment was often terminated prematurely. The newer long-acting depot phenothiazine and similar injectable drugs appear to have provided a partial solution to this problem for patients who will accept them (Crumpton 1968).

The difficulties experienced by relatives in caring for psychiatric patients at home have been documented by a number of writers (Grad and Sainsbury 1963, 1968; Goldberg 1966, 1967; Hoenig and Hamilton 1967, 1969). It has been pointed out that, in practice, the main providers of 'community care' are not the publicly-financed and professionally-staffed services, but the families of patients (May 1965, Wing and Hailey 1974). "In the absence of adequate after-care and rehabilitation services, the term 'community care' could be merely an inflated catch-phrase which concealed morbidity in the patient and distress in the relatives" (Brown et al. 1966, p. 10). This imputation has received some support from a recent study of the problems of families (Creer and Wing 1974).

The concept of 'burden' on the family was introduced by Grad and Sainsbury (1963, 1968), who described the ways in which it occurred and some of the factors which affected the severity of the burden experienced. They reported disturbances of relatives' health (both physical and mental); of the social

and leisure activities of the family; effects on children in the home; disturbance of domestic routine; adverse effects on the family's income and on employment opportunities for family members other than the patient. They found that the most severely affected families at the time of referral were those where the patient's diagnosis was either of an organic psychosis or of a personality disorder.

Both Grad and Sainsbury (1963) and Hoenig and Hamilton (1967, 1969) remarked on the extraordinary stoicism of many family members, in the face of what seemed intolerable burdens. Hoenig and Hamilton introduced the concepts of 'objective' and 'subjective burden' to measure the disparity between the degree of strain reported by relatives and the severity of the difficulties observed. These studies covered all types of psychiatric disorder.

The disruptive effects of caring for a schizophrenic relative at home was described by Brown et al. (1966) and by Goldberg (1966, 1967).

A study of male schizophrenic patients discharged from London mental hospitals in 1959 showed that a majority deteriorated clinically after discharge and that in 60% of cases the patient's behaviour caused severe tension and distress in the home for a substantial period, often terminated by a social crisis (Wing et al. 1964). Goldberg (1967) proposed a classification of family types in terms of the principal relationship difficulties, and maintained that in many cases a better adjustment could be achieved by means of appropriate casework treatment. A more recent study sponsored by an organization which represents the relatives of schizophrenic patients (National Schizophrenia Fellowship 1973, 1974; Creer and Wing 1974; Creer 1975), showed that relatives of sufferers commonly experienced severe difficulties both in the initial stages of the patient's illness, and after he is discharged from hospital. The reports describe in vivid detail, using verbatim transcripts of the relatives' own words, their problems in getting timely help and any sustained and consistent guidance. Many relatives wished they had someone to turn to for advice; they were often bewildered and distressed by the patient's behaviour and were uncertain how he should be managed and whether their attempts were helping or harming him.

Grad and Sainsbury (1968) compared a service whose objective was to treat patients without admission to hospital with another more traditional hospital-centred psychiatric service. They found that severe burdens were equally relieved by both services, but that long-term burdens of more moderate degree were less adequately relieved in the community-based service. This seemed to be due to less active supporting social work services. Attention has been drawn to the unequal scale, distribution and coordination of supporting services, and to the fact that areas in which hospitals attempt to provide community-oriented services are not always those which have adequate supporting services (BMJ 1974, Brook and Cooper 1975).

Thus the findings of other research suggest that the patients of community psychiatric nursing services, whether or not they have ever been admitted to hospital, and irrespective of their diagnostic category, are likely to show a combination of psychiatric handicaps and social difficulties and that these are in many cases synonymous. The families of such patients are likely to have experienced severe stress and in many cases to have lacked support and guidance. These findings may be compared with the information obtained in this study about patients' characteristics and circumstances (section 5).

3.4 'Models' and 'Ideologies' of Psychiatric Care.

In the preceding pages, references have already been made to varying conceptions or definitions of the nature of mental disorder. These underlying concepts determine the objectives and methods of dealing with mentally disordered people which professional workers adopt. They provide a necessary theoretical framework for ordering complex perceptions of psychiatric phenomena, for developing explanations and for prescribing methods of treatment or care. According to Burgess and Lazare (1973), the use of implicit 'models' in clinical situations is both important and inevitable, since they enable meaning to be extracted from events and behaviour which would otherwise remain perplexing and confused. Thus they have a crucial influence upon the way in which workers in the psychiatric field exercise their functions and interpret their roles.

When a single 'model' is zealously or exclusively adhered to, it ceases to be merely an explanatory framework, and can be regarded as an ideological prescription. Studies such as those of Strauss et al. (1964) suggest that nurses do not, as a group, have allegiance to any particular 'model' of mental disorder. (Strauss and his colleagues define ideologies as highly consistent views, synthesizing complex data into a logically consistent whole without empirical validation).

The traditional view on which our existing system of institutional psychiatry was founded is generally described as the 'medical model' — defined by Ullmann (1967, p.26) as follows:

> "In the medical model it is presumed that there is some underlying conflict, disorder, disease or reaction to the environment which is a deviation from a normal state and must be treated prior to and as a necessary condition for altered behaviour."

This model postulates an individual who is 'sick' in that he suffers from an 'illness' which has signs and symptoms and which, given sufficient knowledge and skill, can be diagnosed, treated and cured (or at least ameliorated). The assumption of the 'sick role' as defined by Parsons (1952) allows the ill person to become dependent and to abrogate the responsibilities usually attached to his normal social roles. It may also allow anti-social or deviant behaviour to be 'excused'. There are reciprocal expectations that the 'sick' person should cooperate in the treatment prescribed by competent persons and

should do his best to get better (that is, that he should fulfil the 'patient role').

The 'medical model' became the subject of vociferous criticism, hinging particularly on the inappropriateness of the biological analogy or metaphor for dealing with phenomena in which no biological abnormality has been demonstrated, and which can be more suitably defined as 'problems in living '(Szasz 1961) since they constitute failure in precisely those social roles whose obligations are evaded by the sick person (Sarbin 1969). It is logically inconsistent to apply the disease concept to conditions which are defined by culturally-determined psychosocial or ethical criteria (Mechanic 1962, 1968). It was further objected that the medical approach had failed to produce effective methods of treatment, much less of prevention (Albee 1969). Moreover the application of disease terminology encouraged the encroachment of the medical profession into areas of purely social disturbance (Wootton 1959), and the assumption of unjustifiable powers of control over the liberty and autonomy of individuals (Szasz 1971). This whole field of controversy is very lucidly discussed by Ullmann and Krasner (1965).

A variety of other theoretical models of the nature of mental disorder and of approaches to treatment have been proposed. Some of the former are elaborate - for instance, Siegler and Osmond's typology (1966) of explanatory theories of schizophrenia (medical, moral, psycho-analytic, family interaction, conspiratorial and social) - and may, by definition, exclude any prescription of treatment modes. Schwartz and Schwartz (1964 pp 14-16) recognized four different formulations of the nature of mental disorder, viz: physical-medical, psychodynamic, interpersonal and sociological.

> "Some practitioners think of the individual's disturbances as a mental disease: adopting a physical - medical point of view, they consider crucial the 'illness' aspect of the patient. Others describe the disturbed person as emotionally-psychologically disturbed, as maladjusted, as incompetent or inadequate, as suffering from psychic conflicts or anxiety, or as having distortions of perception or inappropriate affect: theirs is psychodynamic or psychological perspective. Closely allied is the interpersonal frame of reference: the individual is said to have difficulties in living and in relating to himself and others. Finally, a sociological frame of reference presents him as deviant, deficient in role performance, inadequately socialized or unable to meet certain expectations". (ibid.p. 16)

Reflecting that none of these points of view provides a wholly satisfactory explanatory framework, these authors note that there is "no agreement as to which frame of reference is most appropriate to characterize each type of illness" and comment on the problem of integrating them in a coherent form.

In recent years the tendency has been to regard the various interpretative models as alternative, rather than exclusively correct approaches (e.g. Mitchell 1974b). For instance, Lazare (1973) believes that the various major treatment models (medical, psychologic, behavioural and social) should be tried out singly or in combination for their 'fit' in each case, and the most appropriate 'mix' selected. Each, he says, reflects an aspect of truth. Nevertheless he admits by implication the profound difficulty of reconciling these models at the conceptual level, by stressing the confusion which their simultaneous application may create in the minds of patients.

Another recent writer, Havens (1973), has also identified four schools of though in psychiatry - objective-descriptive, psychoanalytic, existential and interpersonal - and has described the characteristic methods of treatment ("technology") for each school. The eclectic approach, as practised at present ("a mixture of methods that 'feel right' ") implies a fragmented and unsystematic form of practice. Havens believes that the various 'models' represent a progressive advance of thought in which the schools emerged one from another, and looks forward to a 'pluralistic' treatment philosophy in psychiatry (ibid. pp. 277-312), without, however, himself suggesting unifying concepts which would help in reaching such a synthesis.

Meanwhile the medical frame of reference has found defenders, chiefly but not exclusively within the ranks of psychiatry. Kendell (1974) has argued that the whole controversy rests on an out-dated definition of the concept of disease. He considers that psychiatry should find its proper sphere of activity in relation to those conditions which place the individual at a "biological disadvantage". Though he would not suggest that psychiatrists should cease to concern themselves also in a more peripheral way with people who are socially disadvantaged, he considers that they should not consider themselves qualified in any distinctive way to practise in this area.

Clarke(1975), a psychologist, shows that the interpretative models used by doctors, even in purely physical conditions, are by no means so simple as the antagonists of the 'medical model' have suggested, and that these ways of thought do not exclude consideration of diverse and often multiple causes and of a range of personal and social as well as biological factors. He advocates the application of a variety of frames of reference: "We must recognize the wholeness of people and avoid both the body heresy and the mind heresy".

There seems to have been a general reappraisal of the value of using 'disease' theories in a more limited way in psychiatry. Wing (1973) compared the merits of 'labelling', 'dimensional' and 'disease' theories as explanatory models for schizophrenic disorders, and concluded that the latter was the most useful because of its predictive power. Wing referred with approval to Mechanic's discussion (1968, pp 91-110) of the function of diagnosis as a prognostic tool in psychiatric practice. Far from suggesting that only physical and pharmacological treatments have a place, Wing maintained that one of the principal arguments in favour of a 'disease' theory is that "the most effective use of pharmacological and social treatments depends upon a proper diagnosis both of the disease and of the accompanying impairments" (Wing 1973, p. 161).

The nursing literature does not waste time over the conceptual problems of the eclectic approach, but assumes that it is necessary for nurses to be able to distinguish between and utilise the different concepts. What implications for the nurse's practice are suggested by the various treatment models? Burgess and Lazare (1973) and Mitchell (1974b) identify the relevant models as 'medical', 'psychological' and 'social'. Kalkman and Davis (1974) make no reference to 'social' treatment models, but discuss instead 'behavioural' and 'unitary' (or general systems theory) concepts. The latter seems to represent the germ of a synthesizing theory, but as its implications in terms of treatment have not yet been worked out it does not claim our attention here. In the medical model, the nurse's main function is to administer drugs and physical treatment, observe the patient's response and report the effects to the physician (Burgess and Lazare 1973 p. 121). In the psychodynamic or psychoanalytic model, it is unusual for a nurse to act as primary therapist unless she has

received advanced training; her role may be to supply data about the patient for use by the therapist in formal therapy sessions. She may also act as adjunct therapist in giving additional psychological and physical care to the patient and assisting him in the practical problems of daily life (Burgess and Lazare 1973, p. 121, Kalkman and Davis 1974 p. 235). In the behavioral model, the nurse's function is to carry out methods of motivating patients to change their behaviour based on Skinnerian learning theory, and other psychological techniques, usually under the direction of a psychologist. "The practice of behavioral therapy requires close ..... observation of the patient's behavior, on-the-spot intervention and correction of undesirable behavior, and frequent recording of clinical data". (Kalkman and Davis 1974 p. 230). The nurse's role in social therapies is not specified by any of these writers, perhaps because in the concept of the therapeutic community, (probably the most influential of the social therapies), so much emphasis is placed on role diffusion and the need for the individual to negotiate his own role so as to make the best use of his therapeutic powers (Jones 1968b). Methods of treatment implied in the social model are therapeutic sessions with groups and individuals aimed at restructuring the social system and the patient's mode of behaviour within it. In this model the nurse must find her own role, although she is "an important link in the implementation of the social model" (Burgess and Lazare 1973 p. 121).

How far do nurses understand and utilise these interpretative models in their clinical practice? In a recent review, Cormack and Fraser (1975) comment on the 'ideological neutrality' of the nurse, which they believe to be functional for the nurse's adjustment to her working situation. They find indications in the literature (e.g. Strauss et al. 1964) that in institutional settings, nurses are not free agents to adopt a treatment ideology other than that subscribed to by their medical colleagues, and argue that psychiatric nurses may not be at liberty to practise a form of nursing which is based on a psycho-therapeutic rather than a medical model. Similarly, Caine and Smail (1967, 1968) found that psychiatric nurses were differentiated, with respect to their attitudes to treatment methods, staff-patient relationships and nurse-doctor role relationships,

according to the predominant approach of the hospital in which they worked. It remains uncertain whether such differences are the result of selection and self-selection for personality characteristics, of attitudes inculcated in training, or of normative social demands and patterns of communication in the various institutions concerned. The roles of psychiatric nurses, particularly in hospital settings, will be further considered below. At all events, it seems likely that psychiatric nurses in 'the community' - in this country as in the USA - may have a greater measure of discretion than their hospital-bound colleagues in defining their own approaches to treatment.

Although it was not the purpose of this study to investigate the treatment ideologies underlying nurses' practice, it is likely that reference to the major trends of thought in psychiatry at the present time may help us to understand their activities better. Moreover some of these concepts have been used by the writer in the analysis and interpretation of data on the content of nurse-patient interaction (section 9) and on the nurses' own accounts of their aims and methods (section 12).

3.5 The Role of the Psychiatric Nurse: Interpretations and Studies

Changes in systems and ideologies of psychiatric care have inevitably called in question the part which should be played by nurses. The psychiatric nurse's role has, during the past two decades, commonly been referred to as 'changing' or 'extended'; but the nature, direction and extent of change is often left to be inferred. In spite of frequent national and international conferences, reports and policy statements on the subject, comments have continued to appear in the literature about the inadequate definition of the psychiatric nurse's role, and about disparities between nursing roles as prescribed and nurses' observed role performance (see for example John 1961, WHO 1963, Altschul 1972, Fraser and Cormack 1975). The issues in question have concerned the nurse's part in the process of change from 'custodial' to 'therapeutic' systems of psychiatric care, and specifically how the therapeutic functions of the nurse should be defined. The following discussion of the literature concerns the major areas of uncertainty about the appropriate role of the psychiatric nurse, and some attempts at identifying the actual components of psychiatric nursing practice. Most of the literature cited comes from British or North American sources. A fuller discussion of this and other related material is to be found in Towell's excellent and comprehensive review (Towell 1975, pp.13-30).

According to an Expert Committee on Psychiatric Nursing convened by the World Health Organization (WHO 1956), the shift from a 'custodial' to a 'therapeutic' role for the nurse was prompted by changes in cultural attitudes and in the focus of psychiatry, whereby the relationship of the patient's illness with his social context was recognised. This new area of interest was exemplified by a series of social-scientific studies of the social structure of American mental hospitals, and of the influence of the hospital environment on the course of mental disorders - including the work of Stanton and Schwartz (1954), Belknap (1956), the Cummings and others (1957), Caudill (1958) and Goffman (1961). In these studies the 'custodial' orientation and its effects on the behaviour and morale of staff

and patients was defined by reference particularly to features of large state institutions. The typical features of custodial regimes were identified as: a stereotyped concept of mental disorders as irreversible disease processes characterized by behaviour devoid of meaning and rationality for which the sufferer should not be held responsible; an overriding concern for the maintenance of order and control, expressed at ward level in an arbitrary system of privileges and penalties; a rigid differentiation of status levels between staff and patients, and between staff groups; impersonality, distrust and alienation in attitudes and relationships. In these institutions the ward management and medical treatment hierarchies operated in virtual isolation from each other, and the conditions of life of the patients were entirely controlled by the ward staff of nurses and 'attendants'. The behaviour of patients in this type of system was characterized by apathy, submissiveness and inability to make decisions, a syndrome also identified in similar ward environments in Britain (Martin 1955, Barton 1959). Ward staff in these systems developed an impersonal, task-orientated conception of their functions, with aims limited to the maintenance of institutional routines, and to the discipline and hygiene of the wards. These staff groups, by virtue of their isolation, tended to be extremely cohesive and resistant to change; norms of work performance were strongly entrenched and rigidly enforced. Custodial attitudes in ward staff were found to be associated with traits typical of the 'authoritarian personality' as defined by Adorno and his colleagues (Gilbert and Levinson 1957). Carstairs and Heron (1957) made similar observations in British environments.

In order to combat institutionalism, it was crucial to change the normative attitudes and aims of nurses and other ward staffs, and to reorient them towards a more optimistic view of their own role and of prospects for the rehabilitation of their patients (Cumming et al. 1957). Barton (1959) analysed the causes of 'institutional neurosis', among which he stressed nurses' restrictive attitudes, and described specific measures by which the condition might be reversed.

There is an extensive literature dealing with the implementation and effects of change in patterns of care in psychiatric institutions -

for example, Greenblatt et al (1955, 1957), Strauss et al. (1964) and Rubinstein and Lasswell (1966) in the USA; Martin (1962) and Clark (1964) in Britain. Much of this work was informed by the idea of the therapeutic community, which was largely pioneered in Britain by Main (1946) and Maxwell Jones (1952, 1968a). The underlying concept of the therapeutic community approach, according to Clark (1965), is the psychodynamic hypothesis - the belief that an individual's difficulties are mostly in relations with other people and can be examined in discussions, understood and remedied. The aim is to make use of the whole of the treatment environment as a medium for therapeutic experiences and 'social learning'. The resources of the entire community, in terms of the personality, experience, insight and sensitivity of each individual is to be brought into play in a process of group interaction and continuous examination of social roles, relationships and structures. Deviant and disturbed behaviour is seen as susceptible to alteration and control by means of group norms and group pressure; the individual is regarded as ultimately capable of taking responsibility for his own behaviour and for profiting from the experience offered to him.

The ideological prescriptions of the therapeutic community approach to treatment include the themes of democratization, permissiveness, communalism and open communication, and reality confrontation (Rapoport et al. 1960). Towell (1975 p. 26) considers that this movement should be understood as a reaction not only against custodial regimes but also against the dominant medical model of psychiatric care.

The reaction against custodialism inspired efforts to define a more 'therapeutic' nursing role. The new emphasis on social and interpersonal processes as determinants of mental disorder issued in a tendency to disparage the nurse's functions as a medical aide, and to define psychiatric nursing as consisting primarily in interaction on a personal level with patients as individuals and in groups. The skills prescribed for the nurse in this model are social and psychological, involving the establishment of therapeutic relationships and the management of the social environment so as to provide "interpersonal opportunities .... wherein the patient may learn about his problems in living with others and have help in solving them through more-productive experience" (WHO 1956).

A series of reports on comprehensive psychiatric services and the nurse's role within them produced under the aegis of the World Health Organization propounded and elaborated these ideas. Of three aspects of the psychiatric nurse's role - technical, social and interpersonal - "the interpersonal aspect is the essential part of her task" (WHO 1956). A conference on 'The Nurse in Mental Health Practice' (WHO 1963) produced a typology of psychiatric nursing skills - viz: basic nursing, technical nursing, occupational and recreational, organizational, interpersonal, observational and communication skills - which emphasised the psycho-social aspects of the nurse's role. Five years later the official British report on the subject, in very similar terms, described skill in personal relations as 'basic' to psychiatric nursing, but revealed some doubts about the relationship between the nurse's ideal role and her actual training and performance: "The psychotherapeutic value of the nurse is not fully recognised" (at present; but in the future) "nursing staff will be required to play a more active therapeutic role and .... they should be prepared accordingly". (Central Health Services Council 1968).

The influence of North American theorists is apparent in these statements. There is a very extensive American literature, much influenced by the writings of Sullivan and Rogers, on the role of the psychiatric nurse and how it should be performed. Altschul (1972) gives a fuller review of the literature bearing on 'relationship therapy', 'nursing therapy' and 'therapeutic interaction' as prescribed for the nurse. Here only a few of the most influential writers will be mentioned. The outstanding theme of these writings is the search for a unifying concept which would define a 'core' element of psychiatric nursing. This was found in the definition of the role entirely in terms of interpersonal techniques and responses, which Peplau (1962) has described as "the crux of psychiatric nursing". The unique aspect of the psychiatric nurse's clinical expertise was the exercise of the role of counsellor or psychotherapist (Peplau 1962: see also Hofling and Leininger, 1960; Travelbee, 1969 pp 6-7; Kalkman, in Kalkman and Davis 1974 p.17). "Therapeutic effectiveness depends upon nursing personnel's understanding the patient's behaviour and responding to it appropriately" (Group for the Advancement of Psychiatry 1961 -

in a handbook produced by a group of nurses, aides and psychiatrists, originally entitled 'The Therapeutic Use of the Self').

Cormack (1974) found that three main types of psychiatric nursing roles were described in the prescriptive literature, based respectively on the use of psychotherapeutic, therapeutic community, and relationship therapy techniques. These roles are performed by means of interaction with patients. In an observational study of Charge Nurses' interaction with patients, Cormack found that the majority of conversations between nurse and patient related to the patient's 'illness'; examination of the purpose of these talks revealed a fact-finding or progress monitoring function. Nurses were not observed to be performing a systematised psychotherapeutic or treatment function.

Attempts have been made to define what kinds of intervention by nurses are most 'therapeutic' and how they can be taught (for instance, WHO 1957). Examples of supposedly helpful and unhelpful responses by nurses in problematical situations have been formulated in relation to theoretical concepts of the dynamics of disturbed behaviour (Schwartz and Shockley 1956, Group for the Advancement of Psychiatry 1961, Hays and Larson 1963). More recently Mansfield (1973) has reviewed some of the work on 'empathy' which tends to show that this quality promotes successful results in individual and group psychotherapy; she suggests that nurses can be taught to show 'empathy'. The extent to which nurses should keep a distance, in emotional terms, from their patients has proved a problem to nurses (Cumming and Cumming 1964 pp. 152-154) and has been widely discussed; this issue is reviewed by Altschul (1972 p. 11-12), and Towell (1975 p.19). Some authorities recommend conscious control by the nurse of her own behaviour, while others favour spontaneous and intuitive responses. Leininger (1961) says: "thoughtful and goal-directed words and actions are characteristic of therapeutic relationships". Nursing texts on 'relationship therapy' prescribe constant awareness on the nurse's part of the patient's needs, and of his responses and her own in the process of interaction. Altschul states (1972 p. 193) that spontaneous human relationships become therapeutic to the extent that they are observed, understood and controlled; but she found that nurses stressed the intuitive nature of the relationship skills. Baker (1969), a psychiatrist, deplored the self-consciousness required by the 'therapeutic' approach, for he believed

that any value which interaction with nurses has for patients lies precisely in its spontaneity and approximation to normality.

Diers and Leonard (1966) have pointed out, however, that it is a research problem to discover which interactive responses, acts or techniques have beneficial effects on patients. After reviewing a number of studies in which constructs derived from sociological and psychological theory were applied to nurse-patient interactions, they concluded that satisfactory methods of analysing and measuring the relevant components of interaction processes could not be developed in the absence of a 'guiding theory' which was relevant to the purposes of nursing. This criticism seems to apply also to the later study by Hargreaves and Runyon (1969), who clearly had difficulty in assessing the significance for patient progress of two distinct interactional styles ('task-oriented' and 'sociable') which they found in use by nursing staff.

There is evidence that the types of interaction which nurses have with patients do have a substantial effect on patients' behaviour and social competence. Wing and Brown (1970) have shown conclusively that varying levels of social stimulation, which included aspects of nursing practice, produced measurable effects on the social performance of long-stay hospital patients. Studies of operant conditioning and other psychological techniques have shown that nurses can influence the behaviour of patients by their use. But the available evidence suggests that the manner in which this potentially powerful influence is exercised by nurses is quite unsystematic and in some instances positively harmful (Fraser and Cormack 1975). It has been shown that nurses in hospital wards will reinforce maladaptive behaviour while they ignore socially acceptable behaviour (Gelfand et al. 1967). There is a good deal of evidence that custodial patterns of behaviour still persist among nursing staff in Britain. King, Raynes and Tizard (1971) compared regimes in residential hostels and in hospitals for mentally handicapped children, using indices derived from Goffman's analysis of the characteristics of 'total institutions' (Goffman 1961), and found that in their terms hospital regimes (conducted by nurses) were considerably more 'institution-oriented' and less 'child-oriented' than hostels. It is often suggested that staff in custodial regimes

are adversely affected in much the same way as patients, becoming subservient to authority, lacking in initiative and unable to cope with change. As recently as 1972, Frost reported noting such reactions among nursing staff in some British hospitals (Frost 1972). Reports of enquiries into 'incidents' in several hospitals in recent years have presented a similar picture (DHSS 1969, 1971, 1972b, and 1974b).

From observations of the actual role performance of psychiatric nurses in Britain it appears that "nurses give rather less emphasis to the personal relationships aspect of their role than do writers of official reports" (Towell 1975 p.18).

Substantial data in this area are somewhat scanty. Three studies carried out in the late 1950s demonstrate the problems of identifying and describing significant aspects of psychiatric nursing activity. These studies were prompted by dissatisfaction with 'custodial' patterns of care; they were designed to explore the existing deployment of nursing staff and to show how they could be employed in a more 'therapeutic' way. Two of these studies - those of Goddard (1955) in the Manchester Region, and of Oppenheim and Eeman (1955) in London - used job analysis techniques borrowed from industrial work study methods, in attempts to identify the functions of psychiatric nurses. These task-oriented quantitative methods failed to show what both authors said they believed were the essential aspects of the nurse's task, by divorcing the activity itself from its meaning for the participants. As Goddard expressed the point: "The one factor which has seemed to be pre-eminent is the relationship between nurse and patient, and this relationship is something which job analysis cannot measure". (Goddard 1955 p. 119).

A study by John (1961) used various participant observation, questionnaire and self-reporting techniques. Her principal conclusions - that there were deficiencies in the provision of both physical and psychological care by nurses in the four Scottish hospitals studied - appear to have been largely based on her own observations; but she did not make explicit the basis on which she selected her material. Her criticisms seem to have related particularly to the failure of some nurses to respond to patients' behaviour as forms of 'illness' - that is to say, in accordance with medically-oriented concepts of disease and treatment.

In the present decade two studies of major importance have appeared in which aspects of the interaction between nurses and patients were elucidated. Altschul (1972) wished to investigate the nature of nurse-patient relationships, but was unable to define that concept in operational terms. She studied instead some features of dyadic nurse-patient interaction in acute psychiatric wards. Altschul found that nurses did not appear to think out why they interacted with particular patients or to consider how they should do so; nor did the content and process of the interaction normally become known to other staff. There was a significantly higher rate of verbal interaction with patients who were physically dependent on nursing care; rates of interaction were also related to the patient's diagnostic category (being significantly lower for patients described as suffering from depression or neurotic disorders). Altschul did not find it possible to interpret these findings in terms of nurses' ideological perspectives; but she noted that in explaining the purpose of their interaction the nurses tended to refer to the patient's behaviour in terms of symptoms.

Towell (1975), using sociological perspectives and methods, described how nurses on three different wards understood and responded to the behaviour of patients. He sought to show how these understandings and responses were influenced by the prevailing treatment ideologies of wards as well as other features of their social organisation. In the light of his findings, Towell questioned the unitary concept of psychiatric nursing and stressed the diverse learning experiences to which nursing trainees are exposed in different ward environments. His analysis revealed widely differing normative treatment ideologies (e.g. Towell, op. cit., Table 6 pp. 135-6). In a geriatric ward the dominant concern of nurses was with the routine provision of the basic necessities of physical existence. There was little concern with treatment other than for physical illnesses, and staff spent very little time in verbal interaction with patients. Consequently, Towell says, patients tended to become "partially depersonalized objects of task-centred routines". In an acute admission ward nurses were strongly influenced by the 'medical model' of disease and treatment. The ward was organized for medical servicing, and the nurses played a linking role between patients and most aspects of hospital arrangements. They were necessarily concerned

with patient management and with acting as adjuncts to the medical staff in somatic treatment. Social interaction with patients was a more discretionary component of their work (op.cit., p.204). Their responses to patients, and particularly the ascription of moral responsibility for deviant behaviour, tended to differ according to how far they regarded them as "ill" (p.205-6). In a therapeutic community ward there were few routine activities or somatic treatments, and nurses were mainly involved in interaction with patients, especially in group meetings. The modes of interpretation employed differed markedly from the admission ward, "notably in leading to a focus on the personal problems of patients and to a view of individuals as being responsible to varying degrees for their actions. In this context 'having problems' could be a sufficient condition for receiving 'help' through social forms of treatment". (op. cit., pp. 198-9, 204-6). The relationship of these three ward ideologies with the custodial, medical-somatic, and social-psychological approaches to treatment described above (section 3.4) is obvious.

Towell notes also that nurses entering the therapeutic community ward found considerable problems in adjusting to the role of a social therapist. Similar problems have been noted elsewhere (e.g., Jones 1968a, Martin 1968). The emphasis in therapeutic community settings upon 'social learning' through personal interaction with other patients and staff members, and the eclipse of pharmacological and physical treatments, deprived the nurse of the exercise of familiar technical skills through which she could 'help' the patient, and at the same time demanded of her a new expertise in understanding and responding to the dynamics of group processes. The therapeutic community ethos also enjoined on the nurse the abandonment of values of discipline and control based on the traditional authority of the doctor and the nursing hierarchy. Towell noted however that nurses tended to show concern about the maintenance of social control on the ward, and to express themselves on such matters in a strongly moralistic tone. Towell ascribes the nurses' problems partly to their previous learning experiences in other environments oriented toward medical conceptions of treatment and a passive dependent role for the patient; and partly to concurrent pressures from reference groups and authority figures outside the therapeutic community ward.

In a recent review of evidence about nurse-patient interaction in various settings, Fraser and Cormack (1975) concluded that nurses do not exploit their opportunities for therapeutic interaction with patients, and that the main reasons for this lie in the lack of definition of the nurse's role in this respect, and the consequent inadequacy of current nurse training programmes. Training "offers little in the way of developing the nurse's therapeutic potential. Rather it is seen to reinforce the prevailing medical model of mental disorder and to perpetuate the delimitation of the nurse's role to that of medical aide".

The current syllabus of training in psychiatric nursing in Scotland (GNC Scotland, 1973) is clearly designed to prepare a medical auxiliary worker, proficient in bedside nursing, clinical investigations and physical treatments. The theoretical content of the syllabus is heavily biased towards biological and medical knowledge. The 'nurse-patient relationship' is mentioned only twice in contexts where it is incidental to other material. Methods of developing or testing interpersonal skills are not mentioned. The English syllabus (GNC England and Wales, 1974), recently revised, presents a more holistic view of the interaction between social, emotional and physical factors in mental disorders, and aims at linking the biological and social sciences and psychiatry. It includes material on nurse-patient relationships and on techniques of communication, and includes provision for practical experience and instruction in "psychological methods of treatment - listening, counselling, reassurance, suggestion, persuasion, hypnosis and group methods". The methods by which these techniques are to be taught are not specified.

It seems clear that it is not universally accepted in Britain that interpersonal skills are 'the crux', or even a crucial element, in psychiatric nursing. Stewart (1975), for example, argues that group training for counselling or similar work, necessarily involving the exploration of feelings, is probably incompatible with hospital nurses' - including psychiatric nurses' - typical adjustment to the stresses of their work, although he considers it useful for nurses moving into the community. Stewart describes the mechanisms of this adjustment in terms closely related to Menzies' analysis of the

management of anxiety by nursing staff in a general hospital (Menzies 1960). This argument - whose merits we need scarcely discuss - exemplifies an uncritical tendency to assimilate psychiatric nursing to the structure and concepts of general nursing, regardless of whether these are appropriate or useful in the psychiatric field. (It has been stated that the standards and practices of general nursing were deliberately introduced into psychiatric nursing in an attempt to raise the status of the mental nurse - Maddox 1957). This is the view of the nature of psychiatric nursing adopted, for example, by the 'Briggs Committee' (DHSS 1972a) whose recommendations place it on all fours with medical or surgical nursing in which it may be more appropriate to apply the 'medical model' of illness and treatment. Such a view raises once again the question whether psychiatric nursing, seen as an interactional process, is really nursing (Thwaites 1973). This question was explicitly dealt with by a Working Group which was set up to consider the integration of hospital and community nursing services in the reorganised Health Service in Scotland (SHHD 1972). This group stressed the social and interactional skills of the psychiatric nurse in the use of relationships and the everyday milieu for therapeutic purposes; but it concluded that differences in nursing practice in different situations were essentially differences of emphasis only.

A number of schemes to train psychiatric nurses for specialised therapeutic roles have been reported in recent years - in group psychotherapy (Forrest and Ritson 1968); child, adolescent and family psychiatry (Haldane et al. 1971); co-therapy roles in small group therapy, marital therapy and work counselling (Morrice 1975); and to undertake behaviour therapy and other psychological treatments (Marks et al. 1973; Hall and Rosenthal 1973; Kiernan 1973). Nurses' potential value in these new roles, except as an auxiliary doctor or psychologist, has been only grudgingly acknowledged (Morrice 1975). American nurses seem to have had some success in establishing themselves as independent therapists in some areas of specialist practice - for instance family therapy (Mereness 1968), or individual and group psychotherapy (Lego 1973, Ujhely 1973) - and are seeking established qualifications and legal safeguards for these roles.

This review has shown that psychiatric nursing shares many of the current ambiguities and problems in understanding the

function of psychiatry in society. It is not at all clear whether the two fundamentally different roles which have emerged - that of a psychosocial therapist and that of an auxiliary worker in a branch of medicine - can be reconciled in one person or whether they will prove to be incompatible.

The practice of community psychiatry had, as one of its points of departure, a new consciousness of the importance of social and environmental factors in psychiatric disorders, and of the disadvantages of the medical frame of reference as a basis for dealing with them. There is some reason to expect accordingly that the practice of psychiatric nursing in the community will show a bias towards psycho-social, rather than medical, perspectives and functions. The literature on the development of community psychiatric nursing, which will be reviewed in the following pages, may show whether this assumption has so far been fulfilled.

3.6 The Development of the Role of the Community Psychiatric Nurse in Britain

This review will be restricted mainly to published material about community psychiatric nursing in this country. There is an extensive literature about parallel developments in some parts of Europe and particularly about 'community psychiatric' and 'community mental health' nursing in the USA and Canada, which is only considered here where it is directly relevant to developments in Britain.

The first recorded community psychiatric nursing service in Great Britain began in 1954, but the literature on the subject is scanty until the early 1970s when a trickle became a flood of descriptive and prescriptive papers, from which only a selection are mentioned in this review.

The history of these services up to 1974 has been reviewed by Hunter (1974), who saw two distinct phases of development - the first (1954-1966) characterized as 'continuing care'; the second (1966 to date) as 'therapeutic work'. Hunter described continuing care as essentially secondary and tertiary prevention in cases of chronic handicap and dependency; therapeutic care incorporated skills being developed by nurses in more progressive services, based on the principles of crisis intervention, psychotherapy, psycho-social nursing, psychogeriatric assessment and treatment, or behaviour therapy. Hunter observed however that his 'continuing care' model was still the predominant one for the majority of psychiatric nurses engaged in domiciliary work. He noted that extended roles for nurses were initiated principally in institutions where therapeutic community or milieu therapy approaches were adopted. The later developments may also be seen in the light of MacDonald's hypothesis (1972) that the mode of operation of a hospital-based community service would invariably be related to the ideological position prevailing in the parent institution. In this sense they reflected a shift of interest away from internal hospital systems (therapeutic community wards and the like) towards the family system as the original unit of disturbance.

The first papers to be published on the subject of community psychiatric nursing were by Hunter, who has been associated with this development since the start. He reported the establishment of a scheme

at Moorhaven Hospital in Devon in 1957 (Hunter 1960, 1962; further descriptions were published by Weeks and Greene 1966, Greene 1968). This service was antedated by the secondment in 1954 of two psychiatric nurses from Warlingham Park Hospital to work in the Borough of Croydon. The impetus for this service was derived from shortage of social workers to provide after-care and out-patient care for an increasing number of patients in the community (May and Moore 1963, Moore 1964).

These two services, as described, seem to have been basically similar in function, but there were important differences in structure and organisation which provided models for two different lines of development, both of which are represented in the literature. These hinged on whether community services should be provided by hospital nursing staff as an extension of their normal ward-based duties, or whether staff should be designated specifically for work in extra-hospital settings. At Moorhaven the first system was adopted. The usefulness of providing personal continuity of care by assigning a nurse whom the patient had known and trusted during his hospital treatment was urged in favour of this model (Weeks and Greene 1966; see also Kirkpatrick 1967, Baker 1968).

In the Croydon structure the nurses worked full-time in after-care and the supervision of out-patient treatment in the home. The work included attendance at out-patient clinics, after-care groups and social clubs, and following up patients who failed to attend. The functions of the nurses were described as purely clinical and were explicitly differentiated from those of the psychiatric social worker: "Detailed investigation of the patient's family situation or modification of his environment and of difficult interpersonal relationships is not expected" (May 1965). This service was supervised by a consultant psychiatrist through weekly case-review meetings.

At Moorhaven, similarity between the tasks of nurses and hospital social workers in this context was explicitly recognised, and accordingly the scheme was supervised by members of the hospital's social work department with a view to helping the nurses to deal with the anxieties raised by working in home and family settings. Specific 'nursing' aspects of their task were also recognised, including the acceptance of an element of dependency on the hospital, and of the

importance of a continued link with the hospital in relieving the anxieties of patients and their relatives. The nurse was able to give physical treatments, to assist the patient in personal care, and to arrange prompt changes in treatment or readmission in cases of relapse.

In both cases a function of the nurse in relation to patients' families was recognized - providing advice and support, and relieving anxiety. Both schemes had importance for nurses by increasing their awareness of family and social aspects of psychiatric disorder (Moore 1964). The dissemination of this influence among the nursing staff of the hospital was one of the objects of the Moorhaven scheme (Hunter 1960). At Croydon the patient was regarded more unequivocally as the locus of disturbance, and the chief value of the nurse-patient relationship was seen in facilitating assessment of the patient's mental state.

Development of services on these models seems to have continued throughout the 1960s. In 1968 Greene summarized the current thinking on the nurse's role in community care thus:

(i) Provision of nursing care of a physical or psychological nature in accordance with the doctor's wishes for patients who have been discharged from hospital and are in need of nursing care:

(Examples of nursing care in this context were supervision of drug treatments and observation of mental states in depressive conditions).

(ii) Working in close liaison with doctors and social workers as professional members of the therapeutic team.

(iii) Extending to the patient and his family such support as may reasonably be regarded as the nurse's work* ("If the illness of the patient is severely disturbing the family, and conversely if family difficulties exacerbate the patient's symptoms, the nurse should immediately seek the assistance of her social worker colleague").

(iv) A preventive function in going to the aid of patients whose illness does not require treatment in a clinic or hospital.

(v) Being available in a consultative capacity to non-psychiatric nurses who may have problems in dealing with patients showing symptoms of nervous and mental disorder.

* Baker (1968) stated, from his experience of supervising nurses working in the community, that they had far more need for help with family interaction and family problems than with problems posed by individual psychotherapy or psychodynamics.

By this time the concept of the nurse as an integral member of a multi-disciplinary team had been accepted. This tended to bring into prominence the problem of differentiating the roles of nurses and social workers in community practice, a subject which will be dealt with in more detail below. The conception of nursing in the community as an alternative to hospitalization was developing (Tumilty 1969). An indirect function through consultation with other professionals had also gained prominence (on the nurse's consultative role see also Central Health Services Council 1968, WHO 1971, and - on the American situation - Deloughery et al. 1971).

These developments followed lines laid down in the remarkably far-sighted report produced for the World Health Organization in 1956 by an Expert Committee on Psychiatric Nursing (WHO 1956). This committee strongly supported the use of nurses in pre- and after-care programmes because of their special skills and understanding of mental disorder. The committee saw nurses as working with families to improve disturbed relationships. In some countries nurses would also deal with financial problems and employment difficulties, and arrange and supervise boarding-out care; but the specific responsibilities of the nurse would vary from one country to another and would depend on the availability of professional workers. The preparation needed by nurses for domiciliary work was also discussed by the Committee, which concluded that, although some of the attitudes and skills acquired in hospital needed no modification, these should be supplemented by "training in the social aspects of her task .... not focussed on the patient alone but on his family and his relationships with the community as well". The content of such further training should include sociological theory and casework methods.

In the early 1970s the activities of more 'therapeutic' services (in Hunter's terms) began to become more widely known, and there was a quick recognition of the need for further training and re-orientation to equip psychiatric nurses for community work. The first course to be approved by the Joint Board for Clinical Nursing Studies (at Chiswick Polytechnic in 1974) followed a conservative view of a mainly after-care function with "psychiatric patients whose progress could be maintained in the community" (Llewellyn 1974). The role of the nurse was defined,

for the purpose of this course, as "a caring role" as opposed to the "enabling role" of the social worker. The Joint Board's own outline curriculum (1974) implied a much more dynamic view of the possibilities of nursing intervention within a predominantly psycho-social interpretation of mental disorder. (The curriculum itself rightly contained no explicit specification of a particular ideological position; such a statement would be out of place in a document intended for national use.)

Several prescriptive statements about the structure and functions of community psychiatric nursing services which have appeared since 1968 continue to describe the nurse's role mainly in terms of follow-up and after-care . In these, the nurse's functions in relation to patients and their relatives are defined primarily as support, encouragement and advice, and there is no expectation that the nurse will use her supposed relationship skills (c.f. Kirkpatrick 1967 on "the use of the self as an instrument of care") to procure change in dynamic factors (Greaves 1972, Sharpe 1975). However a number of reports have also appeared of community psychiatric nursing services based on more progressive principles of therapeutic intervention; a representative selection of these are described below. In these accounts a common feature is the mention of a basic range of nursing tasks, including observation of mental states; detection of organic disease; attention to physical and environmental factors; supervision of medication; but it is clear that these activities may take place within very different frames of reference.

Henderson et al (1973) report on a domiciliary programme in Aberdeen carried out by SENs with extensive psychiatric experience after a short period of initial training and orientation. In this programme, which started in 1969, care is based on principles of psychodynamic psychotherapy. The nurses are expected to be able to identify and explain psychological defence mechanism, to assess and interpret the effects of family relationships on the patients, to recognise problem areas in the treatment situation, and to "mop up" the effects of counter-transference phenomena in themselves and other community workers. The attributes described as important for the nurse in this service were personal traits such as insight into her own psychological make-up and its effects in the treatment situation;

emotional stability and security; and readiness to discuss her own attitudes and feelings. Other aspects of the nurse's role are involved in the work but are evidently considered of secondary importance to the nurse's therapeutic interaction with the patient.

Marks, Conolly and Hallam (1973) reported an experimental scheme in which nurse therapists, after special training and under supervision, executed psychological treatment programmes with patients at home, in hospital and at out-patient clinics. It has been argued that, because these nurses have abandoned the traditional nursing attachment to particular milieux and groups of patients, they have lost their nursing role and have become mere psychological technicians. The aim was, however, to produce a "more independent therapist", and, because of their training and experience with people in mental distress, psychiatric nurses were seen as the most suitable candidates for this new role (Conolly 1973).

The outstanding example of the 'crisis intervention' model of psychiatric community nursing is the role of the nurse in the Dingleton Hospital service, which is an extension of the hospital's internal 'therapeutic community' system (MacDonald 1972; Stobie and Hopkins 1972). Psychiatric disorder is seen as generally a manifestation of disturbed interpersonal processes, and attention is focussed therefore on a family or situation as opposed to a 'sick' person. Psychiatric crises are used as an opportunity to help people to find more productive ways of resolving their personal and interpersonal problems and conflicts. Stobie and Hopkins describe seven elements in the functions of a nurse member of one of the multi-disciplinary psychiatric teams operating from this hospital:

(i) Participation with other disciplines in assessment of patients and families.

(ii) Participation in intervention in crises when admission has been requested. "Physical treatments are used when they promote resolution and not avoidance of the crisis."

(iii) Participation in family and marital therapy.

(iv) Mobilization of community resources and help.

(v) Supportive care of long-term patients in the community and help in the supervision of drug therapy.*

(vi) Prevention of regressed and maladaptive patterns of behaviour in coping with stress.

(vii) Functions connected with the integration of the team's activities, with liaison and consultation between the team and other professional community workers, and with mental hygiene education in the community.

These authors urge the advantages of team treatment methods as opposed to one-to-one forms of care viz: improved assembly, interpretation and communication of data; reduction in dependency, transference and counter-transference problems; shared responsibilities and mutual learning; and improved appraisal of treatment goals and performance.

Altschul (1973) investigated the activities of members of these treatment teams with the aim of finding out what particular contribution (if any) was made by each professional group - particularly nurses. Evidence of differential use of professional skills was not obtained. On the contrary, the hospital culture, emphasising similarities in function, blurring and overlap of roles, and absence of role specificity, was maintained. As to staff orientations, Altschul found some inconsistency in the application of theoretical models; the 'sickness' model was applied to some patients, although mental illness was often interpreted as a failure of interpersonal relationships and some staff members saw their task as that of facilitating the resolution of conflict in families.

A similar approach to the use of crisis situations is demonstrated in reports of 'psycho-social nursing' in a multi-disciplinary team setting at the Cassel Hospital (Haque 1973, Zeal 1973). Admission to hospital is regarded as usually precipitated by the breakdown of care-giving resources, which is to be avoided if possible by constructive resolution of tensions and anxieties.

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* This hospital opposes the administration of drugs by its own staff to patients outside, because it would represent a type of culture in which patients are treated as dependent and childish, and as bearers of pathological symptoms which can only be ameliorated by medication (MacDonald 1972).

The same ideal of intervention to anticipate crisis and promote social learning in the normal environment is expressed also by Marais (1976) who, with others, reports on the nursing contribution to a comprehensive psychiatric service in Bromley. The stated purpose of this group of nurses is to avoid removal of the patient to hospital. The nursing staff are part of a multi-disciplinary service, but appear to do less work with other disciplines than is customary elsewhere. Their service is based at two day centres, and they use these facilities for day care, group therapy, after-care clubs as well as making domiciliary visits. Their functions include both assessment and treatment. They use basic concepts of psychodynamics, psychopathology and psychotherapy, in helping patients to explore their feelings and talk about how they can solve their problems in interaction with the people around them.

An experimental scheme at Oxford, in which hospital-based nurses have also been attached to general practice units and health centres is described in a series of articles by Leopoldt and others (1973b, 1974b, 1975a). In this scheme nurses received direct referrals from general practitioners, some of which were dealt with in conjunction with the family doctor without further referral to the psychiatric team. The nurses' main contributions to patient care through these attachments were in averting the need for hospital admission by early intervention in impending crises, and in facilitating communication between the practice and the hospital. Leopoldt et al. (1975b) also describe the assignment of a community psychiatric nurse to link hospital and community services for psychogeriatric patients. This nurse's work is described as mainly consisting of assessment visits, in conjunction with advisory and practical teaching activities with institutional staffs, professional community workers and patients' relatives. Several other schemes of psychiatric nurses attached to primary care units specifically for the care of the elderly have been reported (by Leopoldt 1975b, Moore 1973, Izzard 1972).

Two debatable points stand out in the literature. The first is the appropriate structure for community psychiatric nursing services. A survey by Parnell in 1974 identified 417 schemes in which 714 psychiatric nurses were working in the community in

Britain. The survey showed that there was no uniformity about the way in which services were organized and staffed, or in their aims or clientele. Many instances were reported in which ward-based nurses were undertaking domiciliary visiting, sometimes on a completely informal footing. Where nurses were specifically designated for full-time community duties, some were employed and based at hospitals, others were employed as primary health care staff and based in the community, others again held joint appointments, and yet others were employed by one agency and seconded or attached to one or more others (Parnell 1974). Nurses have been employed or attached at a variety of treatment facilities and agencies, including health centres, hostels, day centres and social service departments.

Is it preferable to employ full-time 'community' staff or to release hospital ward staff on a part-time 'in-and-out' basis? The arguments are manifold. Ward staff benefit from 'community' experience (Hunter 1960), and patients are said to accept home care more readily from staff whom they knew in hospital (Kirkpatrick 1967, Warren 1971). But continued contact with hospital staff fosters dependency (Sharpe 1975). It is not officially recommended in Scotland that field workers in any branch of nursing should operate in both hospital and community settings (SHHD 1972), presumably on grounds of staffing difficulties and conflicts of priority (Leopoldt 1974a). This dilemma applies chiefly to after-care activities; but it seems to be generally agreed that there is a wider role for the psychiatric nurse in the community which demands the attention of a worker without conflicting priorities. Furthermore it has now been recognized that hospital nurses who have only undergone the existing forms of training for registration in mental nursing are not necessarily equipped with the knowledge and skills required for working in the community, and that further preparation is required (Clark and Jones, 1965, Llewellyn 1974).

Should full-time 'community' staff be employed by and based at hospitals or in the community? Hospital-based appointments allow rotation of internal staff to their benefit and that of the hospital (Moore 1964). Hospital-based staff have closer links with and better access to psychiatric consultation and hospital facilities (Greaves 1972, Leopoldt 1973a, 1974a). Sharpe (1975)

reviews the various arguments in favour of a hospital base but concludes that they are outweighed by other considerations, particularly the belief that a hospital location isolates psychiatric nurses from other community services and fosters patients' dependency on the hospital. The official view in Scotland, however, is that psychiatric patients need a continuing relationship with the hospital and that community psychiatric nursing services should continue to be hospital-based (SHHD 1972). Leopoldt argues the case for full-time hospital-based staff with part-time attachments to primary health-care agencies. This writer suggests an arrangement within the hospital structure which preserves some of the advantages of both the full-time community nurse appointment and the in-and-out system:

> "Internally in each hospital treatment team (consultant firm) one experienced nurse should be given special responsibility for community and domiciliary work. This would not mean that all other nurses would be completely excluded from community work, but it would mean that a particular nurse with prime responsibility would be able to give priority to it. These nurses could coordinate community work with their teams and with the local authority services". (Leopoldt 1974a; see also Kavalier 1972 for a similar scheme).

Where community psychiatric nurses have no hospital attachment, it has been found useful to appoint a senior nurse from the hospital staff to act as liaison officer with the community nursing service (Benington 1971).

The second major debating point is the unresolved issue of differentiating the functions of the community psychiatric nurse from those of other domiciliary health and social workers. The literature cited indicates persistent concern, particularly about the allocation of work between nurses and social workers. Concern was expressed especially by social workers, but also by doctors and nurses. Why was this development necessary? Were some skills required which nurses possessed and social workers did not? Was it appropriate? Did nurses have all the skills required? The answer to the last question seemed to be that nurses were seeking to incorporate in their own training the greater part of a social work education. This suggested that, in their dissatisfaction with their hospital role, nurses were seeking to substitute for it the role of a community social worker (Smith 1969).

Hunter (1974) notes that other professional bodies, including those representing psychiatrists and psychiatric social workers, supported the extension of the psychiatric nurse's functions; but the Association of Psychiatric Social Workers' spokesman at a conference in 1969 expressed the Association's endorsement in very restrictive terms:

> "There is at present a role for the nurse outside the hospital within the limits of his present training. This is confined to educational, practical and therapeutic functions towards patients with organic or chronic disorder with whom he had already built up a relationship in hospital, and to patients in group situations. If some additional training were given, for instance in inter-personal relationships and in the use of the social services, he would be able to expand his work towards those who are less chronically disabled". (Smith 1969)

This position is not substantially altered in the British Association of Social Workers' evidence to the Committee on Nursing (BASW 1971). It has been observed however that health and social workers are very deficient in understanding and knowledge about each other's role, and that this seems to apply with particular force to social workers' perceptions of the community psychiatric nurse's functions (Clark 1973).

Hunter (1960) noted that, at the point of "helping the individual through the relationship", the roles and interests of psychiatric nurses and social workers were complementary. Greater effort has been spent, however, on defining points of divergence. Leopoldt (1973a), a nurse, cites two of the commonest statements (that the social worker deals with the family, the nurse with the patient; that the social worker enables, while the nurse cares) and says they are incorrect . Harries (1972) undertook a three year study in order to differentiate the roles of nurses and social workers in patient care. He compared the answers of ward-based, trained nurses with those of community-based, certificated social workers in response to descriptions of 'similar'(but not identical) critical incidents in psychiatric contexts. To the extent to which his conclusions are not self-evident, they are of doubtful validity, since they were based on responses to different stimuli by groups of people working in dissimilar situations. Altschul (1969) cited a small opinion

survey whose respondents suggested that there was an ideological difference in the ways in which nurses and social workers interpreted abnormal behaviour (nurses: as symptoms of illness; social workers: as provoked by dynamic factors). Sharpe (1975) similarly states that the nurse is concerned with the patient's illness and treatment and its effect on the family, while the social worker is concerned with the patient's social and environmental aspects of prevention and resettlement.

There seems to be a tendency to expect psychiatric nurses in the community to adhere to a 'medical model' of mental disorder, and to suggest, if they do not, that they are aping social workers. To quote Stobie and Hopkins: "People may say that this is social work and they will ask in what way is this psychiatric nursing in the community?" The tendency is seen even among those who endorse therapeutic community methods within hospitals and who by no means think exclusively in disease terms about abnormal behaviour. "Once she is in the community, what does she do? She should be concerned with exercising her nursing skills and not with becoming a pseudo-social worker .... She will supervise Modecate injections, the taking of blood for lithium serum estimations, monitor side-effects of drugs, review diets and other health problems. Participating in domiciliary group therapy, running relaxation classes, and the psychiatric day club are the activities which can be part of her job". (Mitchell 1974).

American nurses say that the nurse's unique contribution to social and community psychiatry is a 'holistic' approach to the patient's experience, deriving from a "broad knowledge base in the biological and social sciences as well as clinical preparation in care, cure and coordination ..... It is the particular combination of skills - components of practice, focus on the client's experience, and a broad background - that makes the nurse a unique and valuable member of the mental health team". (Sedgwick 1975; see also Ujhely 1969, Lego 1973). Leaving aside the influence of the American nurse's more academic preparation for psychiatric and mental health nursing, there is an obvious affinity between their approach and that of British nurses as represented by Leopoldt.

Leopoldt has argued (1973a) that it is wrong to evade the

issue of differentiating roles by reference to role-blurring or areas of overlap. "They certainly exist ..... The larger the areas are, the greater is the need to define the areas which do not overlap, and the roles which do not blur". Leopoldt maintains that the community psychiatric nurse's specific contribution to patient care lies in her unique combination of knowledge and experience; her functions, in his view, are "related to her thorough knowledge and experience of the organic, psychological and social aspects of mental illness". They are not only "in the areas of early detection of mental illness, effects and side-effects of medication, administration of drugs; but they are also in the areas of feeling, behaviour and interpersonal relations". In short, the nurse is distinguished from other workers by her ability to operate within medical, social and psychological frames of reference, either alternatively or concurrently.

The opposing argument is, in substance, that nurses' existing training and experience in hospital equip them to function primarily within a medical frame of reference, and that since other workers can demonstrate greater skills in counselling and interpersonal functioning, nurses should confine themselves to those functions which are part of their accepted role in hospital. In other words, the nurse has acquired a legitimate role creating and managing 'therapeutic' environments within the hospital, but she has established no similar sphere of competence in managing either social or interpersonal aspects of the domiciliary situation. Those who advance this line of argument seem to associate it with an antithetical view of social and health services, in which 'community care' connotes the care of social disabilities entirely by titular social agencies (see page 17).

In his unpublished report Harries(1972) stressed that it was seldom practicable in real-life psychiatric practice to disentangle two separate categories of 'medical' and 'social' problems.

3.7 Summary: Application of the Literature to the Study

In this section, the literature about some general aspects of the community psychiatric nurse's situation and the history of her role was reviewed.

1. The history of the 'community care' idea in the context of psychiatry was discussed. Attention was drawn to several inconsistent interpretations of the concept of 'community care' in the literature. These, if applied by different people at the same time, or by the same people at different times, were likely to give rise to strain and conflict over the definition of the nurses' role in community psychiatry. The material in sections 10, 11 and 12 about nurses' and doctors' views of the functions of the service may show whether this prediction was realised.

2. The concept of social role was outlined, and various theoretical statements were reviewed in relation to evidence about role-relationships in community health services and psychiatric institutions. Exploration of interdisciplinary role-relationships was not among the objectives of this study; but potential difficulties from this source may be borne in mind in considering the data on the nurses' activities in sections 6 - 9. In particular, the influence which doctors may exercise through their control of patient referrals (discussed in section 7) was mentioned. Further indications about psychiatrists' views on the nurses' role in relation to their own, will be found in section 10.

3. Existing knowledge about the experiences, needs and characteristics of psychiatric patients and their families in their homes was reviewed. This evidence may be compared with the information about the characteristics and circumstances of the patients in the study series (section 5).

4. A number of different concepts of the nature of mental disorder was reviewed, and associated frames of reference applied to psychiatric practice were compared. The 'disease' concept of mental disorder, the 'sick role' of the patient and the consequent 'medical

model' of treatment and cure, were explained. Note was taken of nurses' readiness to adopt any or all of the principal models, and of arguments in nursing texts that, in the absence of adequate unifying concepts, the various 'models' should be applied empirically as alternative or complementary concepts. Reference to these concepts may be helpful in understanding the activities of the nurses as reported in this study. Some of them are used in the analysis and interpretation of data on the content of nurse-patient interaction (section 9), and of the nurses own accounts of their aims and methods (section 12).

5. The development of the role of the psychiatric nurse since the end of the Second World War was described - passing from the 'custodial' role, through a phase of identification with general nursing, to current claims to an effective 'therapeutic' role. Reported discrepancies between prescribed nursing skills in nurse-patient interaction, and observations of nurses' performance in hospital settings, were noted. It was suggested that nurses were attempting to combine two separate and perhaps incompatible roles - those of a psycho-social therapist and of a medical auxiliary worker.

6. The history of the extension of the field of work of psychiatric nurses to include patients in their home and community settings was outlined. Two types of development, which continue to co-exist, were described. The earlier type was largely concerned with after-care functions, and often had a marked bias towards 'clinical' concerns, and a supportive type of activity with patients' families. In a later phase of development nurses began to be active in attempting to bring about personal maturation and dynamic change in interpersonal and social relationships through intensive psycho-therapeutic relationships, psychological techniques, the constructive use of crises and the use of community and family resources for care and help. Recognition of psychiatric nurses' need for further theoretical and practical preparation for work in the community situation followed the spread of the second, more dynamic, type of role.

Problems were considered in connection with the organization and structure of community psychiatric nursing services, and in the differentiation of roles, particularly in relation to social work.

These appeared to derive from the absence of an established socio-therapeutic role for nurses outside the hospital. It was suggested that conservative expectations of psychiatric nurses in the community with an emphasis on clinically-oriented functions, may be associated with a conception of community care as comprising totally separate medical and social care systems.

The two latter areas of enquiry were relevant to the whole of this report, and implicit or explicit reference is made to them throughout.

SECTION 4: DESIGN AND METHODS

The design of a study will depend on the objectives which the researcher sets out to pursue. It includes, therefore, formulation of aims, clarification of assumptions, selection of suitable tools, and consideration of time, place, and available resources. It also requires an examination of the researcher's skills and personal interests. Lastly the design will be influenced by the relevant literature. At this stage it is necessary to select and define the terms which are to be used in carrying out the study. The terms used in this report to describe and discuss the study and its results are defined in the text, and in addition a list of definitions is brought together in a Glossary (Annex 4/1).

This section is concerned with all these aspects of the design of this study.

4.1 Evaluation or Description?

In considering a new treatment or service, it is reasonable to ask 'How effective is it, compared with other treatments, or previous systems of care?' According to Suchman, the process of evaluating a programme in health care or allied systems is not different from that of basic research in any other context; evaluation should proceed from an hypothesis of a causal relationship between an activity and some desired effect, and should comprise two stages: first, to establish that a relationship exists ('descriptive evaluation'), and secondly, to show that there is a causal sequence from the activity to the supposed effect ('explanatory evaluation'). "The identifying feature of evaluative research is the presence of some goal or objective whose measure of attainment constitutes the main focus of the research problem". (Suchman 1969 p. 17).

The first question that arose was whether, at the current stage in the development of psychiatric nursing in the community, and within the resources available, an evaluative study was feasible and appropriate.

Evaluation of a psychiatric service, presents formidable technical and practical problems which could hardly have been solved within the limits of the present study. Measures of outcome are notoriously difficult to establish in the field of psychiatric care where treatment methods are largely empirical and treatment objectives are difficult to define in operational terms. There would have been problems in setting up an adequately controlled study. The use of patients as their own controls, by examining their histories before and after referral to the community psychiatric nursing service, would have raised problems in distinguishing between the effect of the community psychiatric nurse's care, and (a) the effects of the depot phenothiazine drugs with whose administration these nurses were increasingly concerned; or (b) passage of time in the natural history of psychiatric disorders. Conditions for a 'natural' experiment, comparing the patients of the service with a group of patients receiving similar treatment from an alternative service, did not appear to exist; no such group existed locally, and it was not possible, within the time and resources available, to create one. The use of such a group in another area(had it been possible to find one) was also ruled out, because, even assuming careful matching of personal and clinical features, it would have been impossible to exclude uncontrolled variables arising from different social and environmental conditions.

In addition to these difficulties, it seemed doubtful if the time was ripe for an evaluative study. The idea of the present investigation had arisen precisely because little systematic information was available about the activities of community psychiatric nurses. It was already apparent that the organization and functions of existing community psychiatric nursing services were somewhat diverse, that they had grown up in a number of different ways, and were evolving rapidly in response to changes in administrative structures and methods of care. (Parnell, 1974, confirmed this picture). It was doubtful whether enough was known about psychiatric nurses' modes of functioning in community environments to enable the effective features of these services to be identified. An evaluative study is likely to be of little use unless the effective features of the programme or system studied can first be identified

and then reproduced, recognised, or assumed to exist in other locations.

The most pressing current need seemed to be for descriptive and comparative material about community psychiatric nursing from several different working situations, which could form a basis for developing a 'model' of such nursing care and for formulating criteria and hypotheses to be used in future evaluative and experimental research. Other factors which influenced the planning of the study were the resources available (in terms of time, money, skill and labour); the limitations of scale arising from the study of a single situation; the research worker's relationship with the participating nurses; and certain ethical considerations. Financial support was available to pay the expenses of a full-time research worker for two years, with occasional secretarial help and some assistance with data preparation and processing. The proposed study situation offered the activities and case loads of five full-time community psychiatric nurses. These nurses were already fully committed to service responsibilities and could not be asked to do anything which might substantially interfere with their work with patients. The small scale of the study and ready identifiability of its subjects required specially careful attention to confidentiality, which was particularly important in view of the nurses' reservations about participating in the study.

4.2 Aims and Objectives

Aims and objectives evolved in the light of these considerations were discussed and approved by the project's Steering Group. The Group emphasised that attention should be focussed on description rather than explanation of the nurses' activities. The following general aim and specific objectives were approved:

"General aim" The nurses working in the hospital's community psychiatric nursing service were trained in the conventional psychiatric hospital setting. Without special training or experience they have undertaken the care of patients in the setting of their homes and families. The object of the study is to show what functions and skills this group of nurses are now exercising, what factors determine or limit their activities, and to what extent their aims and general orientation are modified by the community setting.

"Specific Objectives"

(1) Describe the nurses' working day; their allocation of time, the proportions spent on different types of activity and the geographical location of their work.

(2) Give basic information on clinical, social and demographic characteristics of the people 'served' by the nurses to indicate the nature and range of the problems encountered.

(3) Identify the nurses' activities in relation to individual patients and families (the skills and techniques employed) and relate them to a simple breakdown of diagnostic categories (Schizophrenic/ other).

(4) Describe the clinical, social and other resources used by the nurses for the clients' benefit and their modes of communication with them, and note any evidence of overlapping or conflicting services.

These objectives were to be systematically pursued. In addition two further objectives were adopted on which a certain amount of information was secured, on a somewhat impressionistic basis:

(5) Identify the nurses' chief sources of supervision and consultation; how far the group functions as as autonomous professional unit, and how far the individual members act as independent practitioners.

(6) Estimate how far this service contributes to continuity of care of individuals in terms of treatment policies and of personal contacts, particularly in the process of transfer between hospital and community settings.

It was felt that further important aspects of the situation - for instance the nurses' perception of their patients' needs and problems, their definition of their own aims and functions, their expectations of other professional groups, and their orientation towards the problems of individuals or towards those of families and other social groups - could only be treated impressionistically within the scope of the present study. It would have been very desirable to have enquired into the acceptability of the service to patients and their families, and its influence on the amount of burden or stress experienced by families; but time did not permit the inclusion of these topics. (These important aspects of consumer reaction would probably merit a

separate study designed for the purpose).

4.3 General principles: focus on nurse-patient contact and the whole family as client.

Definitions of the psychiatric nurse's role in the literature give varying degrees of emphasis to her work in relation to patients as individuals compared with her organizational and coordinating functions. A common feature of all role-prescriptions is to stress the importance of the 'nurse-patient relationship'. Some authorities go further, and define interpersonal techniques as the core of nursing. This seemed sufficient justification for defining nursing care, for the purpose of this study, as a process which is transacted between nurse and patient in situations of direct personal contact. The primary focus of the study was placed therefore on events when such contact took place. These events are called 'contacts' in this report. Several recent studies of nursing, health and welfare work have used a similar concept - for instance Altschul (1972) on psychiatric nursing; Marris (1970) and Clark (1973) on health visiting; Rehin and Martin (1968) on mental health social work. In this study, contact was considered to occur when there was an opportunity for verbal interaction - i.e. at face-to-face meetings or in telephone conversations.

From the beginning, descriptions of psychiatric nursing in community settings have given prominence to the nurse's functions in relation to the families of patients, and in dealing with patients in their family contexts. A recent trend in psychiatry has been to regard the family group, rather than a 'sick' individual, as the locus of disturbance. It seemed appropriate therefore to look at the nurse's work with the family group as a whole and with individual family members, as well as in relation to 'identified patients'.

The use of the word 'client' has been proposed "to encompass the two distinct classifications implied by the use of 'individual and family' by the public health nurse, and 'patient and family' by the nurse in hospital" (Lambertsen 1958), and "to express the difference in the nurse's relationship with people at home from those experienced in hospital settings" (Bendall 1973). Bendall attributed

this difference to the fact that "the interaction now takes place in the patient's home, where the nurse is a guest, not a hostess". (This is only one of the changes in role-relationships which the change of environment implies).

In every case reviewed during the study there was an 'identified patient' who had been referred to the psychiatric services for care or consultation, and whose records were held by the parent hospital or another hospital. Each case was designated by reference to the 'identified patient'; but the community psychiatric nurse was not necessarily always concerned primarily with this individual. Her attention might be directed at one time or another to the identified patient, to another member of the family, or to the whole family group. To express this situation, the word 'client' was used to denote both the identified patient and any relative or friend living as part of a family group in the same household. The nurses who participated in the study said they were conscious of a change in the quality of relationships with patients when hospital and community settings were compared, and they accepted the use of the word 'client' to express it.

During the study the use of the term 'client' was useful to avoid confusion between 'patients' of the parent hospital and 'patients' of the community psychiatric nurses. Data were collected in the same form about all contacts with clients (whether the client was patient or family member or both together).

In this report, the word 'patient' is used to denote the 'identified patient'; 'family member' or 'relative' may be used for a member of the patient's household; and 'client' denotes the patient or any member of his immediate family when it is not desired to distinguish between them.

4.4 Design of the Study

The study began with a period of exploratory work during which the researcher observed the Edinburgh community psychiatric nurses at work; familiarized herself with their working situations in the parent hospital; surveyed the literature; developed instruments and schedules for the collection of data; and visited several

other centres where similar services were in operation to observe their modes of functioning and to try out, with the help of their staffs, the research instruments which she had devised.

The research plan comprised three successive stages. During the first stage, data was collected and analysed on the composition of the nurses' working day. The second and main stage of the study was an enquiry into the clientele of the Edinburgh service, and the patterns and situations of contact between nurses and clients. The design of this enquiry combined cross-sectional and longitudinal features. Every case with which the service was in contact during a given period was identified, and the occurrence of repeated contacts was recorded up to a final date. A subsidiary enquiry was incorporated into this stage, investigating in detail the activities and concerns of nurses at a sample of their encounters with patients and family members. The purpose of this part of the study was to delineate the work of the service, first as a whole, and secondly in relation to individual cases; to identify the activities and concerns of the nurses; and to see whether these activities and concerns were related to each other and to characteristics of the patient or of the contact situation. Interviews with the participating nurses during this stage afforded opportunities to enquire into their view of their functions in relation to specific cases.

The third stage of investigation, carried out at and after the end of the main study period, looked at the relations of the service with two groups of professional colleagues, and the latter's expectations of the service.

The successive episodes of enquiry were intended to give some depth and perspective - stereoscopic vision, as it were - to the description of this situation. This approach produced a certain complexity in the research plan. To assist the reader in following the various stages, they are set out in the form of a diagram (Figure 4/1). Table 4/1 summarizes the data and shows when and by what method it was obtained.

Each stage and the methods employed therein are described in greater detail below. Where appropriate, further details of the methods used are presented in connection with the findings in Sections 5 to 12. Copies of the schedules and memoranda used in

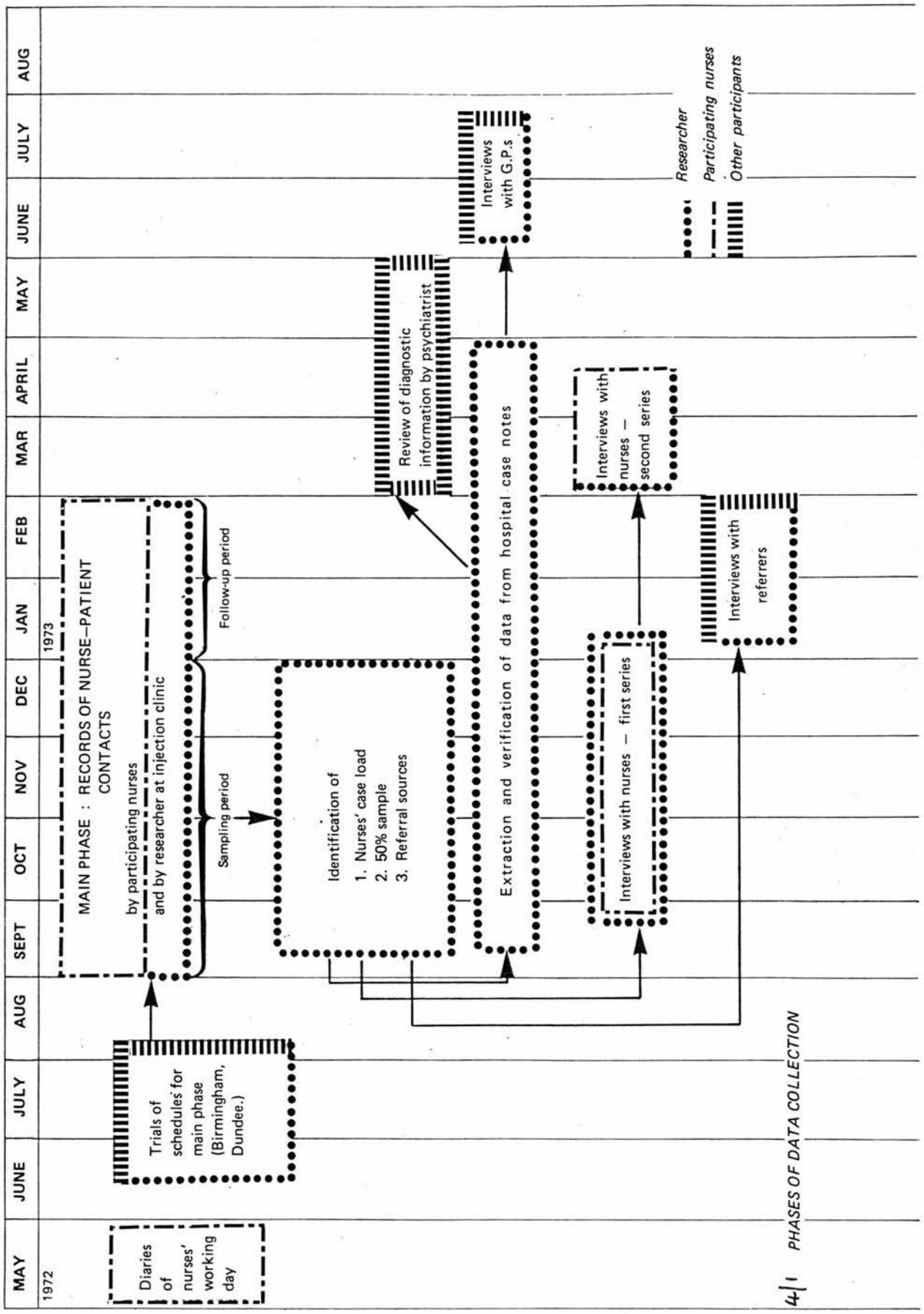

FIGURE 4|1 PHASES OF DATA COLLECTION

TABLE 4/1. Summary of the data

DATA	DETAILS OF SAMPLE AND/OR PERIOD	METHOD OF COLLECTION	INSTRUMENT	DATE OF COLLECTION	METHOD OF ANALYSIS
NURSES' WORK ACTIVITIES					
Categories of work: proportion of working time allocated to each category: location of work activities	Records of work activities of 5 nurses during period of 14 consecutive days	Self-recording using pre-coded activity categories	Diary sheets (A 4.2/2) and key list to categories (A 4.2/1)	May 1972 (repeated by one nurse in March/ April 1973)	Transferred to work sheets; electronic calculator used to compute results
NURSES' CASELOAD					
Number and identifying details	All cases in which contact took place (N = 308)	Identified from nurse/patient contact records	Contact record schedule (A 4.3/1)	1 September 1972 to 31 December 1972	Transferred to card index
PATIENTS					
Demographic characteristics: psychiatric history and current treatment	All cases (N = 308)	Inspection of case-notes and other hospital records	Data schedule - 'Case record section A' (A 4.4/1)	September 1972 onwards	Recorded on Hollerith punch-cards for computer analysis
NURSE-CLIENT CONTACTS					
Number, date, frequency, initiator location, persons present, change or stress observed	All contacts for 154 cases (50% of sample) Number of contacts:- sampling period N = 801; follow-up period N = 360	Self-reporting by participating nurses (community contacts); observation by researcher (clinic contacts)	Contact record schedule (A 4.3/1)	1 September 1972 to 28 February 1973 (Sept. to Dec. 72 = sampling period, Jan. to Feb. 73 = follow-up period)	-do.-
Content and process: Activities, areas of observation, topics, interpersonal procedures	Series of 100 consecutive contacts from each of 5 nurses (N = 500) Included cases from sample and non-sample groups	Self-reporting by participating nurses, using pre-coded check list	Contact activity schedule (A 4.3/2)	From 1 September 1972 to date of completion of series (variable)	-do.-
NURSES' PERCEPTION OF PATIENTS'					
living situation, social competence mental state, special problems	50% sample of cases (N = 154)	Semi-structured interviews (2 series)	Interview schedules 1st series: Case-record section B (A 4.4/2) 2nd series: Case-record section C (A 4.4/3)	1st series: September to December 1972: 2nd series: March to April 1973	-do.-
NURSES' DESCRIPTION OF CASES					
Methods and objectives of management, sources of referrals/ consultation/ professional, contacts	-do.-	-do.-	-do.-	-do.-	Computer analysis: analysis by hand of verbatim extracts from interview data
COLLEAGUES' OPINIONS OF THE SERVICE					
Hospital psychiatrists and others	Representatives of teams or individuals who referred one or more cases to the service during the sampling period (N = 21)	Semi-structured interviews	Interview schedule (A 4.6)	January to February 1973	Analysis by hand from transcripts of tape-recorded interviews
General practitioners of patients seen by the service	Random sample of GPs of patients who received at least 4 home visits during the study period (N = 30)	Semi-structured interviews	Interview schedule (A 4.7)	June to July 1973	-do.-

the collection of data are appended (Annexes 4/2 to 4/4, 4/6 and 4/7). Details of ratings and criteria used in preparing and classifying the data for analysis are explained in Annex 4/5.

4.5 Methods of Enquiry

The methods used were varied, and included observation, extraction of data from hospital records and structured and semi-structured interviews; but preference was given to a variety of self-recording methods.

One of the questions which the research worker had to consider was her own role vis-a-vis the community psychiatric nurses, particularly with reference to the extent to which it would be feasible and appropriate to use observation, in a participant or non-participant role, in the collection of data.

Theoretically the social roles available to a research field-worker range from complete observer (with or without open acknowledgement of the worker's research function, but without participation in the situation observed) to complete participant (usually with concealment of the research intentions of the worker) (Gold, 1958). At least two intermediate roles have been described, in which observation and participation are combined in different proportions. According to Junker (1966, p. 37), a role in which "the observer activities are made publicly known at the outset, are more or less publicly sponsored by people in the situation studied, and are intentionally not 'kept under wraps' ", is known as 'Observer-as Participant'. In this role, Junker says, the research worker enters into an implicit contract to observe the same distinctions as his subjects as to what is and is not to be made public, and thus is obliged to accept constraints on his reporting. Gold(1958) discussed the extent to which, in studies where an observer gradually develops relationships with informants, he is "apt to spend more time and energy participating than observing". Junker makes the point that, in practice, the field worker's position is likely to shift from time to time between the various theoretical stances.

During her first few weeks in contact with the Edinburgh

service, the researcher tried out varying levels of participation as an observer at nurse-client contacts. Her role was approximately that described as 'Observer-as Participant'. Within it she noticed shifts in her relationship with the participating nurses similar to changes described by Øyen (1972) in the role of a 'Neutral Observer' of small, executive groups - being initially regarded with suspicion as an inspector; then in a second phase treated (by some nurses) as an adviser and consultant and quite subtly tempted to intervene in the situation; and finally allotted the role of an autonomous observer. Unlike Øyen, this researcher did not reach a stable 'autonomous' role, and found that throughout the study her relationship with individuals and the group oscillated between the three positions. The researcher came to the conclusion, after these trials, that her presence as observer at nurse-client contacts in most situations would inevitably produce bias. It was clear that her presence was unwelcome to some members of the service and that interviews with some clients would not be available for study. In a purely practical way, her presence would often displace that of another person or colleague of the nurse. More important, she found that clients made persistent attempts to involve her in the interaction, and that she was unable to remain quite passive or to assume a position which was ideologically neutral or indistinguishable from that of the community psychiatric nurse. For these reasons it was decided to avoid using participant observation particularly in the domiciliary situation.

In considering possible ways of collecting information about what the nurses did, the researcher had essentially only two choices - between direct observation and self-reporting methods. Four main reasons contributed to the decision in favour of the latter:

(1) The problems of maintaining a 'neutral observer' posture.

(2) Complete information about all the contacts between individual clients and the service could only be supplied by the nurses themselves.

(3) The literature showed that previous studies using observational methods had failed to demonstrate what the authors considered to be the essential aspects of the psychiatric nurse's task, because these methods divorced the performance of actions from their purpose and significance for the nurse and the patient (Goddard 1955, Oppenheim and Eeman 1955).

(4) Using observational methods, the research worker would inevitably interpret what she saw in terms of her own background and experience, which was likely to differ in ideological content from that of the nurses participating in the study. Valid data were more likely to be obtained if nurses described and explained their own activities and perceptions within a framework provided by the research worker.

Consequently little use was made of direct observation, whether in a participant or non-participant role, for the collection of systematic information. But the research worker had considerable personal contact with the participant nurses throughout the study period through attendance at their weekly unit meetings and injection clinics, through the research interviews at which the nurses' cases were discussed, and through simply being 'about' the same buildings. The impressions which she gained from observation of the nurses at work, from formal and informal contacts with them, with patients, and with other members of the hospital staff, have no doubt had an important influence on her interpretation of the data and formulation of conclusions.

In the following paragraphs the stages of the study, and the methods used in them for the collection and analysis of data, are discussed in detail.

Preparatory trials

It was not practicable to carry out a complete 'pilot' investigation because neither the time-scale nor the local conditions of the main study could be simulated elsewhere. With the cooperation of community psychiatric nurses based at hospitals in Birmingham and Dundee, draft versions of the instruments used in the second stage of data collection were tried out in conditions not unlike those of the Edinburgh study; these trials enabled the researcher to detect and revise ambiguities in wording, to gain experience in using the interview schedules and to estimate the time required to complete the record forms.

Stage 1: The nurse's working day

An investigation of the types of work carried out by the nurses during their working hours, the distribution of time between them, and the locations where work was done, formed the first stage of the research plan. Work activities outside normal working hours (viz: at evenings and weekends) were included. Nurses were asked to complete diary sheets (Annex 4/2.2) with which they received a coded list of activities (Annex 4/2.1.). To complete the sheets it was necessary to identify the code which applied to a particular activity and to enter it, together with the time of starting and finishing the activity. Nurses were also asked to indicate by another set of codes the location in which the activity was carried out; for this purpose the City of Edinburgh was divided into seven areas, corresponding roughly with the administrative units then in use by the social work department, which were also used to allocate spheres of interest to clinical teams in the parent hospital.

The pre-coded activity categories had been defined after some weeks of preliminary observation, and a small trial was carried out by the Edinburgh nurses before the actual record weeks, to identify defects in the definition of categories and to accustom the participants to the use of the codes and diary sheets.

The diaries were kept by all participant nurses for a simultaneous period of two weeks in May 1972. A duration of 14 days (including evenings and weekends) was chosen because there seemed to be a two-weekly rhythm about many of the nurses' activities. For instance, nurses generally attended at the injection clinic in alternate weeks, and a larger number of patients were said to be visited fortnightly than at any other interval of time.

At the time when the diary record was kept, one of the nurses had been newly appointed and was undergoing an orientation programme. It was felt that her activities during the record weeks might not be representative of her normal pattern of practice. This nurse therefore repeated the diary record during two weeks in March and April 1973. The results were remarkably consistent with those of the

previous year. The fifth nurse's results for the two weeks in 1973 were combined with data from the other four nurses' 1972 records in the reported findings. This exercise confirmed the impression of the participating nurses and the researcher that the structure and activities of the service had remained virtually unchanged during the study.

This enquiry was an instance of the problems and difficulties which direct observation methods would have involved in view of the peripatetic working situation of the nurses. The self-reporting method provided a more complete, and probably a less biased account of their activities. It also allowed a simultaneous record to be made, which was of particular interest in regard to the location of the nurses' work and the areas which they covered.

For analysis the data were transferred to work sheets. The duration and proportionate allocation of time to activities and locations were calculated and checked against the original records using a hand-operated electronic calculator.

A separate investigation was required to show the nurses' activities at the weekly injection clinic. This was the only phase of the study in which non-participant observational methods were used. There were often several people present at the clinic who did not take an active part in the proceedings - sometimes visitors who came to observe - and the research worker found that it was possible to become part of the background without apparently changing the nurse-patient interaction or the pattern of work.

Four broad categories of activity were selected which could be applied by the researcher on the basis of observation alone, and which did not involve any element of interpretation of the nature of the activity. The proportion of time which nurses spent on each category was recorded at four successive clinic sessions. A simple form of time sampling was used: at intervals of 15 seconds the researcher noted in a fixed sequence what each of the nurses conducting the clinic was doing and assigned it to one of the four categories. After practising the method the researcher found that the number of observations which she recorded was within 3% of the expected number, and she concluded that the method was reasonably accurate. The number of observations in each category was totalled, and it was

assumed that the activity occupied a proportionate fraction of the total time which the nurses spent in the clinic. Periods of absence from the clinic (either on the researcher's part or that of the nurses) were excluded from the calculations.

Further observations were made at four successive clinic sessions to show the length of time spent by patients in the clinic. This was done by recording, for each patient, the time of entering and leaving the clinic (accurate to the nearest quarter of a minute). These observations were also analysed using a manually operated calculator. The results of this stage of the study are given in Section 6.

Stage 2: The main study - contact between nurse and client

The purpose of this part of the study was to delineate the work of the Edinburgh community psychiatric nursing service in relation to 'clients' over a period of several months; to identify activities and concerns of the nurses; and to see how these activities and concerns were related to each other and to characteristics of the patient and situation.

A. The record of contacts.

Using a standard schedule (the 'contact record' or 'contact-slip', Annex 4/3.1), the participant nurses were asked to record each occasion during the six months from 1 September 1972 to 28 March 1973 (the 'study period') when they had contact with a client. The record was completed on each occasion by the nurse primarily responsible for the contact. Contacts which took place at the nurses' injection clinic were excepted from this request, and contacts in that setting were recorded by the research worker who attended every clinic session during the six-month study period. This was done to avoid imposing extra work on the nurses at the busy clinic sessions.

The major consideration in the design of the contact record was to make it simple and quick to complete, as it was to be used several times daily by each participant throughout six months.

Originally it was planned to ask for a 'reason' for each

contact; but when this was attempted during the trial stage, it was found that the responses introduced several different levels of explanation:- initiatory acts by others; the nurse's own intention in making the contact; and the predicted situation of the client. As the record was completed after the event, 'reasons' were also contaminated by the actual situation found or the outcome of the contact. Evidently the nurse's motivation for making a contact could be more complex than had been realized. A full investigation of this matter seemed to be beyond the scope of the present enquiry, but might repay separate study. It was decided to include a question about the initiation of contacts, as this was one indication of the extent of nurses' autonomy in the organization of her work.

A memorandum explaining the intended use of the contact record and defining some terms was prepared to assist the participating nurses (Annex 4/3.3; this goes on to deal with the 'activity schedule' - see below).

Information from the contact-record series was used in four ways:-

(i) To identify the case-load of the service

All cases in which a patient was offered care by the service during the four months 1 September to 31 December 1972 ('the sampling period') were identified from the contact records. A serial number was given to each new case; the numbers were allocated strictly in the order in which the 'key contact' for each case was notified to the research worker.

(ii) To provide a sampling frame

It was decided to draw a 50% sample from the nurses' case-load for more detailed study through interviews with the participating nurses. The sample was drawn by a 'systematic' method - by taking alternate cases from the series, viz: those bearing uneven serial numbers. This method of drawing the sample, an approximation to random sampling, was used because it enabled cases to be allocated to sample or non-sample groups before the whole series had been completed. A true random sample could not properly have been drawn until the whole series of cases was complete. By this systematic method it was possible to hold interviews about new sample cases immediately after the notification of the key contact, instead of waiting for the end of the sampling period.

The distribution of several variables (sex, age group, social class, diagnostic category - schizophrenic or

other, prescribed treatment, and patient status) in the sample and non-sample groups was compared and no significant differences were found. (Details are given in Annex 4/8).

(iii) To study contacts between the service and its clients during a given period

801 contacts in the 154 sample cases took place during the sampling period (1 September to 31 December 1972). It was assumed that these represented a 50% random sample of all nurse-client contacts during that time. Features and circumstances of this sample of contacts were explored. The findings are presented in Section 7.

(iv) To study patterns of contact in individual cases

Frequency and other aspects of nurse-client contact in individual cases were examined. The participants were asked to maintain their records of nurse-client contacts for two months after the sampling period ended - the 'follow-up period' from 1 January to 28 March 1973 - so that contact in sample cases could be observed for periods ranging from two to six months, depending on the date of the key contact. Findings are presented in Section 8.

B. Records of content and process of interaction between nurses and clients

In order to obtain detailed information about what took place at contacts between nurses and clients, each participant was asked to complete an additional schedule at 100 consecutive contacts starting at the beginning of the study period. The schedule (Annex 4/3.2) took the form of a descriptive check-list. There were four sections, covering topics discussed, activities of the nurse, areas of observation or assessment, and the interpersonal procedures used by the nurse. Items in these sections were to be ticked if the nurse considered that they played a significant part in the contact event. The explanatory memorandum (Annex 4/3.3) provided for nurses' use contained examples of how the definitions of interpersonal procedures might be interpreted.

The five individuals completed their 100th activity schedule respectively in the 7th, 11th, 12th, 15th and 26th weeks of the

study period. (The variation in the periods covered was partly due to sickness and other absences and was unexpected). The whole series of 500 activity schedules represents equal-sized samples of the work of each of the participant nurses; it does not represent a sample of the work of the whole service during any given period.

The analysis of this material showed how items on the check list were related to the circumstances of contacts and to the characteristics of identified patients in the relevant cases. The extent to which the various items were linked together in practice was explored using a form of linkage analysis (McQuitty 1957). The findings from this part of the study are presented in Section 9.

C. Use of documentary sources

The researcher examined the hospital case-notes on every patient in the total series (308 patients). Personal and clinical information about each patient, his psychiatric history and treatment was recorded (for the data schedule used see Annex 4/4.1 - 'Case Record part I '). Other documentary sources were also used where necessary to complete the data - viz: the community psychiatric nurses' case-notes and records of drugs administered; also records kept by the records department of the hospital (including day-patient attendances, admissions and discharges, and the legal status of patients placed under restriction).

Diagnostic information for each patient in the series was reviewed by a consultant psychiatrist.

This information is presented in Section 5, which also contains further descriptive information provided by nurses at interviews.

This part of the project proved unexpectedly time-consuming; the task of tracing the whereabouts of case-notes which were in active use (as was often the case with newly referred cases), borrowing and restoring them in all parts of the parent hospital was really arduous.

D. Interviews with participating nurses

Each of the 154 cases in the sample was the subject of either

one or two interviews with the community psychiatric nurse who was primarily responsible for that patient's care. The first interview was undertaken as soon as possible after the 'key contact' was notified. It was designed to elicit the nurse's perception of the patient's personal and family characteristics, social and environmental circumstances. It also covered some aspects of the nurse's experience and objectives in dealing with the case. A semi-structured form of interview was used, a list of questions (Annex 4/4.2) being used as an interview guide.

In 43 cases out of the total sample of 154, the interview was not successful because the nurse knew too little about the patient and family to be able to respond to the questions. More or less complete information was obtained in the remaining 111 cases.

The second interview, for which a similar technique was used, took place at the end of the study period (March - April 1973); these were not attempted unless the first interview on the case had been successfully completed. These interviews dealt with aspects of the patient's treatment and care during the study; the nurse's perception of the social and behavioural problems of the patient and family; and the nurse's contacts with other health and welfare services in connection with the case (see Annex 4/4.3).

The intention of carrying out the interviews in two stages was to be able to obtain (at the first) information about the nurse's view of the case before the frequency of nurse-client contact was recorded; and to make retrospective enquiries (at the second) about some aspects of the nurse's work on the conduct of the case during the study period. In the event there was not enough time to make full use of these fine distinctions in the analysis of the data, and the two-stage interviews proved an embarrassment. The respondents felt that they had already covered the ground adequately at the first interview; the researcher found that the additional information gained was hardly worth the time and trouble; and both (for different reasons) thought it was time to bring the collection of data to a close. In retrospect the cumbersome two-stage procedure was seen to have been a mistake.

Data given by the nurses about patients and their families are presented in Section 5 of the report. Some of the nurses' responses about their working aims and perspectives are examined in detail in Section 12; others are referred to from time to time through this report.

E. The analysis of the data.

The material from the main study was coded in numerical form and transferred to Hollerith punch cards for computer analysis. The data was of two kinds, one series relating to cases and the other to contacts, and their manipulation to enable one type of information to be related to the other presented certain problems. Computer programmes written for the purpose by staff of the Edinburgh Regional Computer Centre made it possible to carry out the analysis using a standard 'package' computer programme - the 'Statistical Package for the Social Sciences' (Nie et al. 1970).

Associations and differences between variables are not (unless explicitly stated) quoted in this report unless they reached statistical significance at the 5% level or beyond - that is to say, unless the probability of an association or difference of such magnitude happening by chance was not more than 5 in 100. Standard Chi-square tests of association were used. For contingency tables with more than 2 x 2 variables, values of X^2 were partitioned where necessary using Kimball's formulae (Kimball 1954).

Stage 3 : Interviews with professional colleagues about the functions of the community psychiatric nurse

There were two groups of people whose views seemed likely to have particular relevance for the development of the role and functions of community psychiatric nursing services. The first group were the people who referred cases to the nurses; these constituted a most important 'evaluative reference group'* for the nurses, in that it was they who enabled them to practice. The second group were general practitioners whose patients had received care from the community psychiatric nursing service; their views were expected to show the opportunities and constraints of the nurses' work in the extra-hospital setting. Accordingly interviews with representatives of these groups were planned to round off the study:

(i) Referrers 21 individuals who were known to have referred cases to the service during the sampling period were interviewed during the early weeks of 1973. Details of how this group were selected are given in Section 10, where the findings are also reported.

(ii) General practitioners 30 general practitioners were interviewed during June and July 1973. These respondents were selected by a random method from lists of doctors whose patients were seen outside the hospital at least four times during the study period. Details of the method of selection are given in Section 11. All of the doctors who were approached agreed to be interviewed.

The purpose of the interviews was to explore respondents' experience of the service and their views about its functions. The interviews were semi-structured, using a list of questions as an interview guide, and the methods of constructing and conducting interviews were the same for both groups, though the content of the interviews differed. In each case, unstructured discussions with a few individuals were used to explore the field and develop topics for discussion, and the interview guides (Annexes 4/6 and 4/7) were

* See page 26

derived from these. The order of questions was not strictly adhered to, but where possible the same ground was covered in all interviews. The researcher carried out all of the interviews. Their duration varied from 10 to 75 minutes.

A tape-recorder was used to facilitate accurate recording of the interview, unless the respondent refused permission or was obviously disturbed by the machine. None of the referrers refused permission, but two general practitioners objected to being recorded, and two others appeared so uneasy that the researcher stopped the machine and relied on her notes of the interview. All respondents were given an opportunity to make further comments after the recorder had been rather ostentatiously switched off; this manoeuvre elicited much interesting material, particularly from general practitioners, though it was not always directly relevant to the topic in hand.

Verbatim transcripts were taken from the tapes; summaries and edited extracts, made from the tapes and from the researcher's notes of the interviews, were used for the analysis of the material. The verbatim transcripts were not retained. Considerable difficulty was experienced in classifying some of the material since numerous shades of opinion were expressed without any obvious polarization. Where the data could be coded by categories, it was possible to use Cope-Chat cards, sorted by hand, in the analysis. The findings from these two series of interviews are presented in Sections 11 and 12.

4.6 SUMMARY

In this study the community psychiatric nurse's work was considered to be legitimately directed to family groups as well as individual patients; this was recognized by designating both as the 'clients' of the nurse. 'Nursing' was considered to take place in situations of personal and verbal contact between nurse and client.

Data was collected in three distinct stages: the first was an enquiry about the nurses' allocation of time to types of work and location, using self-reporting of pre-coded activities on diary sheets.

The main part of the study formed the second stage, which covered a period of about six months. In this phase the chief instruments were self-administered record schedules completed by the participating nurses, but a variety of other methods was also used, including semi-structured interviews with the nurses. The nurses' case-load was identified, nurses' patterns of contact with patients and families were studied, and some aspects of nurses' work in these contexts were discussed.

The design of the main study combined longitudinal and cross-sectional features: the nurses' active case-load throughout a four-month period was identified, and action in each case was then followed from the 'key contact' until the end of the study period.

The focus throughout the study was on the nurse's work in relation to particular cases, on the nurse's definition of her own activities, and on her perception of her clients and their needs and problems.

The third stage of investigation comprised two series of interviews with users and potential users of the service - people who referred cases to the nurses during the study, and general practitioners whose patients received domiciliary care from the service.

PART II - FINDINGS OF THE STUDY

The next eight sections explain and discuss the information gained by the methods described in Section 4 above.

SECTION 5: THE PATIENTS

It was decided that, in this study, the essential process of nursing should be looked on as a transaction between two parties - the nurse and the patient. In this light, the nurse's actions are in some sense a response to the patient, his needs and his situation as the nurse perceives them. Therefore, to understand what nurses do, one must study the patients and how the nurse sees them.

Some of the information in this section was given by the participating nurses at interviews; some came from the hospital case-notes which were available to and used by the nurses.

A list was compiled from the contact record schedules of all the 308 cases with which the nurses had contact during a four-month period (1 September 1972 to 31 December 1972). This list was not the same as the index of current cases maintained by the community psychiatric nurses, which included in-patients of other hospitals, people who had refused service or disappeared, and others kept in view through an informant. For the purpose of this analysis of the nurse's work, the series of cases was intended to include all those with which the nurses actually had contact during a given period. The series thus included a number of in-patients and day-patients of the parent hospital with whom the nurses had some ad hoc contact, and excluded long-term cases which were for the time being dormant.

5.1 Findings

Details of the data summarized in this section are set out in the tables in Annex 5. Personal and demographic characteristics of patients, clinical history, status and treatment are described first. This information, which is given about all 308 patients in the series, was derived from the hospital case-notes, and was recorded in the Case-Record, part 1 (Annex A4/4.1). Secondly, data are given about patients' living

conditions, social performance and mental state. This information relates to a sub-sample of 111 patients, was obtained from the participating nurses at two series of interviews, and was recorded in the second and third sections of the Case-Record (Annexes A4/4.2 - A 4/4.4).

Several of the variables studied were expected to show differences between patients diagnosed as schizophrenic and others; the distribution of the variables concerned was analysed in relation to diagnostic category, and the results are shown separately in the tables.

Age and sex (Table A5/01)

80% of patients were aged between 25 and 64. The median age for men was 42, for women 50, and for both sexes 49. Taking both sexes together they were more or less evenly distributed over the four decades of middle life. There were few patients under the age of 25; numbers also fell off at 65+ and very markedly at 75+. The oldest patient was 86 and the youngest 16 - a range of 70 years.

There were more women than men in the patient series. The graph (Figure 5/1), comparing the age distribution for the sexes, shows both the overall preponderance of women in the series, and the difference in age distribution, the peak for men being around 30 but for women between 50 and 60. The only age group in which men outnumbered women was between 25 and 35; there were no men over 75 in the series.

Marital status and situation (Table A5/02, /03, and /04)

Half of the patients had never been married. 30% had legal marriages still subsisting, but only 21% were actually living with their spouse, and 2% were 'cohabiting'. The rate of marriage breakdown in the series, as shown by legal separation or divorce, was 16%.*

* These figures may be compared with data for the age groups 25-65 in the 1971 census for the City of Edinburgh. Between these ages the proportion of unmarried people in the population of Edinburgh was 15% and that of married people was 78%. The proportion of divorced people among those who were or had been married was 2%; the corresponding proportion for the study was 14%.

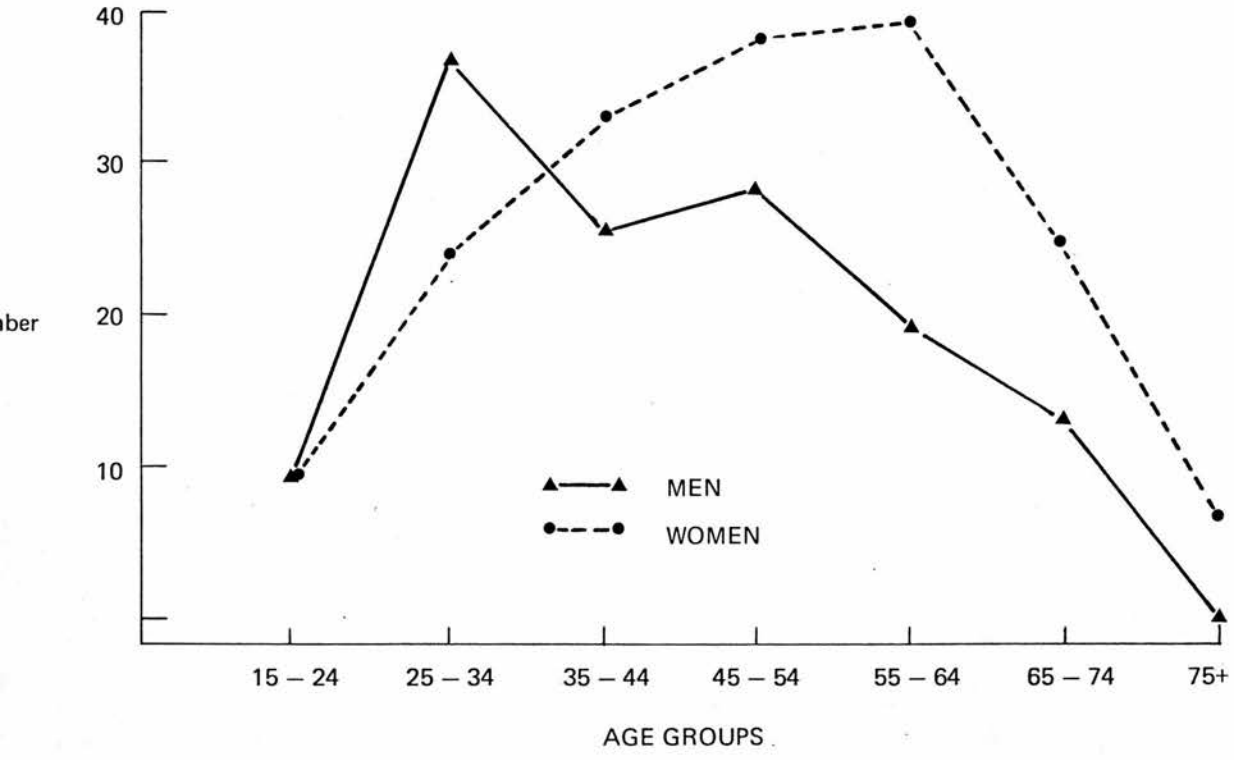

FIGURE 5/1. NUMBER OF PATIENTS BY AGE & SEX.
(10-year age groups)

In the schizophrenic category the proportion of single people (56%) was significantly higher than among the non-schizophrenic group.

Social class (Table A5/05)

Social class was defined according to the Registrar General's classification of occupations (1970). The patient's latest-known job was used or, in the case of a married, widowed or divorced woman, her husband's job.

People diagnosed as schizophrenic were relatively more likely than others to be in social classes IV and V (semi-skilled and unskilled occupations).

Table 5/1

Social class by diagnosis

(Number of patients)

Social class	Diagnosis		All diagnoses
	Schizophrenic	Not schizophrenic	
I- III	(93)	(79)	(172)
IV and V	(86)	(34)	(120)
	(179)	(113)	(292)

X^2 6.53, 1 d.f., $p < 0.05, > 0.01$

Psychiatric diagnosis* (Table A5/06)

The diagnosis was recorded following a review of each patient's case-notes by a consultant psychiatrist, who contributed the following comments on the diagnostic criteria adopted:

> "Most of the patients were known personally to the recorder but, with regard to the remainder, discharge letters to general practitioners and case summaries were available. In case of doubt colleagues who dealt with the patient were contacted.
>
> "The classification of the diagnosis was chosen to eliminate secondary diagnosis as much as possible in order to simplify the issues. This may indeed over-simplify the patient's clinical and personality problems.
>
> The classification chosen within the schizophrenic diagnosis was: paranoid schizophrenia; non-paranoid schizophrenia; and schizophreniform illnesses. Paranoid schizophrenia included the classical cases incorporating thought disorder, but also those whose experiences were dominated by passivity feelings. Non-paranoid schizophrenia covered the classical Bleulerian concepts of simple schizophrenia, catatonic and hebephrenic patterns, which are often blurred by phenothiazine treatment. Schizophreniform cases covered the diagnostic doubts (but in the context of the full contents of the case-notes), in addition to those with notable affective elements and organic backgrounds.
>
> "Personality disorders were classified according to the outstanding features over the period recorded in the notes.
>
> "It is probably worth noting that in recent years the treatment philosophy of the Hospital has put more emphasis on patients' dependency problems and reactions to environmental pressures, of which the community nurses will be made aware in their contacts with the ward teams".

A schizophrenic type of illness was diagnosed in 62% of cases. All the other major psychiatric disorders were also found, with the exception of drug addiction which was recorded as a secondary factor in two cases only. Secondary diagnoses were made in 9% of cases only and have not been included in this analysis.

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* I am indebted to Dr. J.W. Affleck for reviewing the diagnosis in every case in the series, and for contributing the paragraph on diagnostic criteria.

Table 5/2

Diagnostic Category by Age

(Number of patients)

Diagnosis	Age Group		All ages
	up to 54	55 +	
Schizophrenic	150	39	189
Not schizophrenic	54	64	118ø
	204	103	307

X^2 35.3, 1 d.f., $p<0.01$

ø The age of one patient was uncertain

A majority (74%) of the patients under 55 years of age had schizophrenic disorders, but among those over this age the proportion was smaller (38%) and was equalled by the number of those with depressive illnesses and psychoses of organic origin (see Table A5/06).

Psychiatric treatment (Tables A5/07 and A5/08)

Depot phenothiazine drugs (long-acting tranquillizers given by injection at intervals generally of 2 to 4 weeks) were prescribed for 53% of the patients (78% of schizophrenic patients) at the time of their 'key' contact. Almost invariably the injections were given by the community psychiatric nurses, either at the injection clinic or at the patient's home.

The principal forms of care in use were routine out-patient supervision, nurses' home visits and drug therapy. 17% of patients were receiving some other form of care, notably day care in the hospital. Day care was given in several different settings* within the hospital with

* Industrial rehabilitation unit, day hospitals for short-term and long-term rehabilitation, occupational therapy departments and certain of the medium and long-stay wards.

a variety of aims, including rehabilitation to normal work, prevention of deterioration in long-term handicap, and relief of burdens on families and community services. Day-patients were found in all age-groups except 75+. Day-care was not associated with any particular diagnostic category.

Patient status (Table A5/09)

A distinction was drawn between patients who were supervised at home by a community psychiatric nurse, and patients who attended psychiatric out-patient clinics (including the nurses' injection clinic where a psychiatrist was usually available to see patients if necessary). The former were called 'Community patients' and the latter were designated 'Out-patients'. About 50% of the 308 patients were out-patients; 20% were community patients, and a further 25% were in-patients or day-patients of the parent hospital. It was found that diagnostic category was significantly associated with patient status - schizophrenic patients were more likely to be out-patients than non-schizophrenic patients, and less likely to be looked after by a community psychiatric nurse at home.

Table 5/3

Patient status by diagnostic category

(percentage and number of cases)

Patient status	Diagnostic category				All cases	
	Schizophrenic		Non-schizophrenic			
	%	(n)	%	(n)	%	(n)
Out-patient	60	(113)	37	(44)	51	(157)
Community patient	12	(23)	32	(38)	20	(61)
Other	28	(53)	31	(37)	29	(90)
		(189)		(119)		(308)

X^2 21.998, 2 d.f., $p < 0.01$

Psychiatric History (Tables A5/10 to A5/14)

68% of the patients were known to have had at least three admissions to psychiatric hospitals - in some cases many more. 45% had a past history of psychiatric hospital treatment dating back more than ten years. Only 10% had been admitted for the first time less than a year before the 'key contact'. 3% of patients had never been admitted to a psychiatric hospital and 5% had been out of hospital for more than five years. The others (91%), who had all been in hospital during the previous five years, included 11% who were actually in-patients at the time of the 'key' contact, and 47% who had been in hospital during the preceding year.

Schizophrenic patients were more likely than the others to have had multiple hospital admissions:-

Table 5/4

Diagnostic category by number of admissions

(Percentage and number of cases)

Diagnostic category	Number of admissions				All cases	
	None/one		Two +			
	%	(n)	%	(n)	%	(n)
Schizophrenic	41	(24)	66	(164)	61	(188)
Non-schizophrenic	59	(34)	34	(85)	39	(119)
		(58)		(249)		(307)

X^2 10.871, 1 d.f., $p < 0.01$

In the majority of cases the patient's latest spell in hospital had been less than 3 months, but 10% of patients had a latest stay of over 2 years.

19 patients (7% of the total) were subject to orders for compulsory treatment at the time of their 'key' contact; 5 of them were in-patients, 6 were in the process of admission to hospital, and 8 were on leave of absence or conditional discharge from the hospital.

Physical illness or disability (Table A5/15)

30% of the patients had a long-term physical illness or disability which was noted in the hospital case-notes. 10% had more than one kind of disability.

The degree of disability was rated by the researcher on a three-point scale in accordance with the effect of the illness on the patient's employment chances, personal independence, domestic life and social contacts. 'Moderate' or 'severe' degrees were found in 14% of the patients - much more often in the elderly than in the under-45 age-groups.

A wide variety of disabling conditions was involved. More than half were degenerative diseases - cardiac failure, chronic bronchitis, hypertension and cerebro-vascular disease being the most frequent.

The data discussed above related to the whole series of 308 cases. The information discussed in the next part of this section was derived from the research interviews with the participating nurses, and relates to a sub-sample of 111 cases (see section 4, p 90). Aspects of the patient's social performance and circumstances were discussed and ratings were made by the research worker on the basis of the nurse's description. The rating criteria are specified in Annex A4/5, items 45-70.

Disorders of Mental State and Behaviour

Early in the study period the nurses were asked to make an assessment of the patient's mental state at the most recent contact, and to cite significant mental symptoms and signs. They were asked: "In general would you say his mental symptoms seriously affect his ability to cope with living in the community?" The answers were rated in accordance with the effects of the symptoms on employment chances, personal independence, domestic life or social contacts. 21% of the patients were considered completely incapacitated in one or more of these respects by their state of mind; on the other hand more than half (55%) of the sample did not appear to be significantly affected by mental symptoms.

Table 5/5

Rating of patients' mental state

(Percentage and number of cases)

MENTAL STATE	%	(n)
No abnormality observed	26	(29)
No significant effect	29	(32)
Restricts social competence	22	(24)
Incapacitating	21	(23)
Not known	3	(3)
		(111)

Nurses were also asked: "Is his behaviour at present liable to be a serious handicap in the community or a nuisance to others?" Behavioural disturbance was rated as:

Severe — Likely to lead to a social crisis or justify emergency action

Moderate — A public or family nuisance or a cause of serious interference with social adaptation

Minimal — The patient shows one or more types to a moderate degree but can and does control them when required to do so.

Disorders of behaviour were reported more frequently than disturbed mental states; some form of disordered behaviour was recorded for almost 60% of the patients, though the degree was minimal in 25%. Only one case of severely disturbed behaviour, according to the criteria adopted, was described out of the whole sample.

Table 5/6

Rating of patients' behaviour.

(Percentage and number of cases)

Disturbed or disturbing behaviour	%	(n)
None described	41	(45)
Minimally disturbed	25	(28)
Moderately disturbed	33	(37)
Severely disturbed	1	(1)
		(111)

Ratings of impairment in mental state and behaviour were significantly correlated ($r = 0.68$).

Social capacities (Table A5/16)

Nurses were asked about the patient's competence in three types of activity which are normally required for independent adult life in our society. These were mobility (getting about outside the home, using public transport etc.); coping with personal hygiene and dress; and the use and control of money.

Incompetence in personal care was the most frequently reported social handicap (35% of cases); problems of mobility and managing money were observed in 14% and 24% of the cases respectively. Difficulties in travelling and managing money were associated with restricting or incapacitating mental symptoms, but there was no association between mental state and poor self-care.

Employment record (Table A5/17)

85% (94) of the patients were unemployed at the time of the first research interview; 5 of these individuals had worked intermittently during the previous six months. Only 12% of the sample (13 individuals) worked consistently during this period.

The nurses were asked to say why each of the unemployed people was not working and the responses were classified as follows:-

Had reached retirement age	20
Full-time housewife or student	10
Financially independent	2
Physically unfit for work	4
Mentally unfit for work	24*
Seeking work but could not find it	5
Made no effort to get work	24
Could not keep a job	3
Reason not known	2
	94

* Five of these were hospital day-patients

Patients who showed a moderate or severe degree of behaviour disorder or mental abnormality were a little more likely than others to have been consistently out-of-work; but the difference in work record was not very marked.

Financial situation (Table A5/18)

The nurses were not confident in answering questions about finances, and gave more "don't know" responses about managing money than about other kinds of behaviour. The responses indicated that only about 10% of clients were living on their own earnings, while over 40% depended on Social Security benefits. As many as 15% were believed to have private means. The nurse thought that 9% of the patients were living on inadequate means (7 out of the total of 10 were dependent on Social Security benefits). In 7% of cases the nurse believed that the patient was currently in debt; not all of these individuals were considered by the nurse to be badly off.

Living environment (Table A5/19)

57% of the patients in the sample (63 individuals) lived in a family group. 23 patients lived with a parent or parents; in 17 of these cases one or both parents were over 60 years of age, and in 6 of these, 75 years or more. 15 of the families included children of school age, and 8 families had children under 3. 23 out of 63 households consisted of the patient and one other person:

Spouse (or common-law spouse)	7
Parent	7
Sibling	6
Child	2
Friend	1

18% of the patients (20 in number) lived alone. Of 19 over-65s in the sample, 13 lived alone, 1 with a relative, and 5 in a boarding-house or residential institution.

24% of the patients in the sample lived in some kind of residential institution- hostels, residential homes or nursing homes (16), or supervised lodgings (11). 48% of the patients were house-

holders or the spouses of householders.

The nurses were asked to describe any inadequacy in housing conditions. Problems were reported in 18% of the sample cases - about one in four of those who were not residing in an institutional setting. Housing problems varied from unsuitability (house too large, too many stairs) or neglect (dirty, ill-furnished) to structural defects and lack of basic facilities. A few (6) patients were living in houses in multiple occupation (in bed-sitters or 'flats') but only 2 of these were considered to be unsatisfactory.

Social Contact

Nurses were asked to estimate the frequency of the patient's social contacts outside the household. 86% of the patients in the sample (96 individuals) appeared to have some kind of friendly social contact at least once a week. 25 of them were living with their families or in institutions and were thought to have very few or no other contacts outside the house; but it was not considered possible to assess the amount of social interaction within households. Only two patients were believed to be completely isolated from family and other social contacts; 7 others were thought to have very infrequent social or family contacts. None of these suffered, in the nurse's opinion, from a subjective sense of isolation. 25 patients in the sample were reported to suffer to a moderate or severe degree from feelings of loneliness or isolation; half of these lived in family or institutional settings, and nearly all of the remainder were believed to have regular social contacts of some kind. No association was found between advancing age and isolation or subjective loneliness.

Special problems (Table A5/20)

The list (Annex A4/4.4) of the type of problems and difficulties of daily life which have been found to affect psychiatric patients in the community was developed from the work of previous researchers (Jefferys 1965; Rehin and Martin 1968). The nurses were asked at the second research interview to identify problems

on the list which had affected each patient and family since their original contact with the community psychiatric nursing service. Table A5/20 shows how often each problem was cited, and how often it was considered to affect patients and relatives respectively. The problems have been arranged in the table in order of frequency. The most frequent are largely concerned with problems of personal relationships and motivation. Specific socio-environmental problems, such as housing, employment and money, take a somewhat less prominent place, but had affected as many as 30% of the cases .

5.2 Discussion

The data presented in this section and in Annex 5 show that the nurses' clientele were not a homogeneous group showing uniform characteristics and predictable problems. They included individuals and families of diverse backgrounds and circumstances, with varying kinds and degrees of disability and manifold problems. In discussing majority tendencies and shared characteristics, it is important not to lose sight of the range of variation among the people and problems encountered.

It is proposed to draw attention to some of the outstanding characteristics of the clientele and to consider what factors could be held to have produced this particular 'mix' of patients.

Some of the features of the nurses' clientele were apparently associated with specific nursing tasks. The outstanding instance is the preponderance of schizophrenic patients (63%) in the case-load. A large majority (78%) of the nurses' schizophrenic patients were receiving depot phenothiazine drugs by injection, and this in itself would be enough to account for their referral to the community psychiatric nursing service. Similarly, it seems likely that people with concurrent physical and mental disabilities were referred preferentially to this service. The rate of physical illness or disability among the patients appears to have been high; but there was no means of comparing it with a general level, since the incidence among other psychiatric patients in similar situations is not known.

An administrative decision within the parent hospital decided the age structure of the clientele. It was considered that patients of working age were neglected in comparison with adolescent and elderly patients, who were already catered for by a number of special services. Thus it was a simply decided to attach the nursing staff of the service to those clinical areas of the parent hospital which dealt mainly with people below the age of 65.

It was evident that the patients were closely associated with psychiatric hospital care; a majority of them had had a long history of chronic or recurrent psychiatric illness and a recent short admission, and were currently in treatment by the parent hospital as an

in-patient, day patient or out-patient. The present writer has questioned whether this pattern would be likely to occur except where the service was based at a hospital (Sladden 1974).

The expected picture of long-term ex-hospital patients, socially isolated, lacking family ties and with no settled home to go to, was not appropriate for the majority of the clientele. More than half of the patients in the sample lived in a family home. A substantial minority (about 25%), however, were resident in lodging-houses and institutions - nursing homes, residential homes, hostels and the like. Supervision of these and other patients in outside accommodation may have been a more onerous task than appears from the proportion of such patients included in the nurses' case-load. A number of people were kept in view, as it were, indirectly, through consultation with the staff ormanagers of residences; but unless there was actual personal contact between the nurse and the individual patient during the sampling period, the patient was not included in the study series.

The data on the environment and problems of the sample patients supported the researcher's impressions, gained from meeting and observing many of the patients of the service, that the majority of them were integrated at some level into settled social or family units, and that gross forms of disorganization and deprivation affected only a small minority. Many of the severely disorganized characters who congregated in certain parts of the city were seen from time to time at moments of crisis, but their way of life was so unstable that it often proved impossible to maintain contact with them. Departures from acceptable behaviour tended to be unspectacular; the more sensational forms of social aberration - violence, drug abuse, sexual deviation - were occasionally encountered, but seldom in extreme forms.

Nevertheless many of the problems and difficulties indicated in the literature (reviewed above at pages 35 to 39) were observed in this setting. Behavioural handicaps were quite severe in their effects and were compounded by a variety of other difficulties (Table A5/20).

Failure to work was the most obvious and frequent departure from normal social behaviour, with all that it implies of financial hardship, social stigma and loss of self-esteem. Only a small proportion of patients seemed able to persist in a job for more than a few months

and the majority were chronically unemployed.

The community nurses themselves and other informants attached considerable importance to their ability to 'establish relationships' and to communicate effectively with people suffering from severely disordered mental states. The nurses' own accounts of the sample of patients, however, showed that, on specific occasions in the recent past, rather more than half of the patients had displayed little overt mental disturbance. The psychotropic drugs with which the majority of patients were being treated were apparently more effective in suppressing mental signs and symptoms than in modifying disturbed behaviours which seem to have been widespread, at least at a minimal level.[ø]

Complete isolation from sociable contacts (using as a measure the estimated frequency of family and other contacts) was very rarely reported. Complete seclusion, where it occurred, was a form of disturbed behaviour which was very difficult to ameliorate, especially if the nurse's own visits were refused. (This happened from time to time and may account for the absence of complete social isolates from the clientele).

Isolation or loneliness in a subjective sense was one of the problems most often attributed to patients by the nurses. Subjective feelings of loneliness often seem to have denoted incapacity to make satisfactory relationships, even with people living under the same roof. Similar handicaps are shown by the observation that more than half of the patients had never married or were divorced or separated, and by the high proportion of cases in which extremely disturbed family relationships were reported. Disturbed relationships in the patient's family or marriage were the most prominent among the social problems reported by the nurses.

ø There was a positive correlation between ratings of disturbance in behaviour and in mental states, but the relationship was not one of complete correspondence. This confirms that the nurses used different criteria to assess mental states from those applied to behaviour.

5.3 Summary

The outstanding features of the clients of the community nursing service at this hospital, taken as a group, were as follows:

age between 25 and 65 (the years of normal working life)

diagnosis of a schizophrenic type of illness

history of chronic or recurrent psychiatric illness of many years' duration

close current association with psychiatric hospital care, including a recent short admission and current treatment by the hospital as an in-patient, day-patient or out-patient

current treatment with injectable psychotropic drugs

an incidence of physical illness or disability which was probably above the average for psychiatric patients

residence in a settled environment (either with relatives or in an institution) generally without severe problems of poverty, social isolation or physical surroundings

unemployment and lack of motivation to work

some disturbance of overt behaviour not necessarily associated with serious mental symptoms

marital status often single or separated

problems of personal relationships particularly within the marriage or family circle

The majority of these characteristics were attributable to the structure and location of the service in the context of hospital care, to administrative decision, or to patterned expectations of the functions of the service. Other features have been identified which seemed to be intrinsic to the population represented by the clientele: these included moderate degrees of behavioural disturbance, chronic social problems particularly concerning family relationships, and failure to cope with the demands of normal employment.

SECTION 6:

PATTERNS OF WORK:

THE STRUCTURE OF THE NURSES' WORKING DAY

The identity of an occupational group is defined by its particular or unique function; but the performance of this function does not necessarily absorb the whole or even the major part of its time. Thus it was at one time generally assumed both by the public and by the profession that nurses spent their time caring for the sick; and it came as a surprise to all concerned when it was demonstrated how much domestic work was done by nurses (Nuffield Provincial Hospitals Trust 1953).

If their title was anything to go by, the defining function of 'community psychiatric nurses' would be the nursing of psychiatric patients in 'the community' (that is to say, not in hospital). It was not known exactly what the activities of these nurses were - their type, their absolute and relative duration and where they were carried out - and whether they corresponded with the label. An analysis of the distribution of working time between broad categories of activity was therefore carried out as the first phase of the study. The method used was based on the completion by the nurses themselves of diary sheets, showing how much time was given to pre-coded types of activity. Details of the method used are given in Section 4 (p 84); the diary sheet and the key to location and activity codes are reproduced at Annex 4/2.1 and 4/2.2.

Some information was also obtained about the geographical location of the work of members of the service outside the hospital, to show how it was distributed between different areas of the city. This is not discussed in detail here although a distinction between hospital and other environments has been retained.

In the analysis, the work of the five participants has been aggregated. The effect of individual differences is not the concern of this study and has not been examined. Individual differences did, of course, exist and were probably particularly influential in this setting where individuals were largely free - and indeed obliged - to organize their own time, taking into account the needs of their own particular clinical attachment and any special task which they undertook on behalf of the group.

6.1 Hours of work

The community psychiatric nurses worked a five-day week, and the service was officially not available at evenings or weekends. In fact visits were made outside normal working hours, and the nurses' hours of work were somewhat variable. They had an office in a detached part of the hospital complex of buildings, and they usually started and ended the normal working day by calling there.

6.2 The classification of types of work

No analysis can be better than the classification on which it is based. The categories used for this part of the study were mainly intended to distinguish between clinical and organizational concerns: they were formulated by the researcher on the basis of her preliminary observations and were defined as follows:-

Visit/interview with client/family
- routine
- non-routine
- related to emergency admission or compulsory detention
- abortive visit

Injection clinic

Discussions with colleagues - directly concerned with individual client/family

Finding accommodation, visiting lodgings and hostels, contacts with lodgings/hostels staff etc.

Attendance at social clubs, voluntary organisations.

Ward meetings, psychiatric team meetings/case conferences.

Other meetings and discussions

Reading and writing case-notes, other office work, personal contacts connected with administrative matters.

Research activities

Travelling and time expended on car (except providing transport)

Providing transport for others

Meal-times, relaxing, personal

Other

Nurses were asked to provide their own description (under 'Other') of items of work which were not covered by the pre-coded categories; these items accounted for 1% of working time. The descriptions of 'other' activities were varied; examples are given in Table A6/1. The pre-coded categories were used in respect of 98% of working time, and thus proved to be reasonably comprehensive.

Some of the individual categories may require comment or explanation:

There were two categories within which personal contacts with patients and relatives ('clients') were recorded; these were 'Visits and interviews' and 'Injection clinic'.

Visits and Interviews

Most of these took place at the patient's home, but interviews could take place elsewhere - for instance at the patients' place of work, or at the parent hospital's premises. Contacts at the injection clinic were recorded under a separate heading.

Visits were seldom at pre-arranged times except when they were for the purpose of giving a routine injection. The nurses gave two reasons for preferring not to make appointments. Firstly a better impression was gained of the client's state of mind and situation if he had not been able to prepare for the visit beforehand. Secondly, it was essential to keep a flexible work schedule without too many fixed appointments in order to be able to deal with emergency calls and requests for urgent visits at short notice. The community psychiatric nurses were frequently asked to call on patients who had not appeared for treatment, day care or out-patient appointments; or to look for in-patients who had absconded. Tracing absconders and non-attenders was often time-consuming and difficult. For all of these reasons, therefore, a proportion of abortive calls was accepted as unavoidable.

The third category of visits(that related to emergency and

compulsory admission to hospital) needs a word of explanation. The members of this community psychiatric nursing service accepted the task of escorting to the parent hospital patients who were so disturbed that they urgently needed hospital care (whether compulsory or informal). (Before the reorganisation of the local health and social work services, this task was often undertaken by mental health officers). Such occasions were not frequent but when they occurred they might occupy anything from a few minutes to several hours. The nurses considered that they had developed a certain expertise in dealing with these difficult situations with a minimum of distress for the patient and his relatives.

Injection Clinic

This clinic was held at the main hospital building on one afternoon a week. The self-administered diary method was not suitable for recording nurses' activities at the clinic; these were observed by the researcher using a time-sampling method (see Section 4, p. 85–86).

The clinic was conducted by two or three nurses, always including two of the community psychiatric nurses, who attended in rotation. A psychiatrist was usually available during clinic sessions to see patients either by appointment or at the request of the nurses.

One nurse acted as receptionist and scribe, while a second prepared and administered injections in a side-room. If a third nurse was present, she generally observed the proceedings without taking a very active part, except in record-keeping. The community psychiatric nurses kept records of patients' attendances, injections given or withheld, and changes in treatment. At the end of each clinic session, the list of attendances was checked and it was decided how to deal with absentees - whether to visit them at home, send an appointment for the following week, or take no action.

A computerized system of recording and monitoring the progress of discharged schizophrenic patients was in the process of being established at this time (Affleck and Forrest 1971). The psychiatric team which was responsible for this scheme also undertook the direct supervision of the injection clinic. The

clinic provided an opportunity for the community psychiatric nursing staff to exchange information and discuss problems with the psychiatrists who conducted the follow-up scheme; this is one reason why "consultation with colleagues" was a substantial activity at the clinic (See Table A6/4).

Some (not all) of the patients attending the clinic were included in the computer-assisted follow-up scheme. Data slips recording attendance also included standardized information about the patient's treatment, his work record, and an assessment of his mental state. The data slips were usually prepared by the nurses in consultation with the psychiatrist.

Meetings and Discussions

The principal types of formal meetings attended by the nurses included:

(a) a weekly meeting of the community psychiatric nursing staff with their Unit Nursing Officer, at which Unit policy and management problems were discussed and current work was reviewed.

(b) clinical and ward team meetings. These varied according to the type of service - whether acute admission or rehabilitation areas were involved. The purpose and scope of these meetings was often ill-defined. In addition to clinical matters the content might include the discussion of ward policy and administration, teaching of theoretical material, and adjustment of interpersonal staff conflicts. Weekly team meetings usually included a review of all current in-patients. Often there was also a weekly case-conference at which newly-admitted patients were 'presented', or cases posing problems of diagnosis or management were discussed in detail. Some wards also held daily 'community meetings' or group therapy sessions which the community nurse was invited to attend.

(c) regular meetings on special topics which were relevant to community nurses' work - for instance, rehabilitation services in the hospital, and liaison with the local authority psychiatric after-care hostel.

(d) meetings of nursing staff in particular grades or areas as part of the structure of communication developed within the hospital.

These meetings provided opportunities for informal consultations with colleagues from other areas or disciplines.

Two items particularly implying contact with extra-hospital agencies or staff were included: these were "Finding accommodation etc" and "Attendance at social clubs and voluntary associations".

Finding Accommodation etc.

This item really denoted the maintenance of liaison with a range of residential facilities in the city. The initial task of the service had been to help long-term hospital patients to establish themselves 'in the community' (Nickerson 1972). Members of the service were still quite frequently asked to place patients in suitable accommodation at the time of discharge from hospital; the amount of work fluctuated depending on the demand and the availability of places. Contact had been established with hostels, nursing homes, private hotels and boarding houses. The establishments most often used were visited regularly by one or other of the community nurses, both to supervise patients already placed there, and to keep up a contact with the staff. Visits to patients were recorded under the appropriate heading: liaison with staff could take place by telephone or by personal visits.

Social Clubs and Voluntary Associations

The literature suggested that community psychiatric nurses elsewhere were active in such enterprises, and members of the Edinburgh service had taken part in local voluntary social activities.

Office Work

"Office work" included ordering drugs and supplies, preparing for the injection clinic and completing records afterwards, and the inevitable array of returns, statistics and correspondence. (It did not cover the work of reception and recording carried out at the clinic). The major task was the maintenance of case-records. Four types of records were kept:-

(i) a card index of patients' names and basic details

(ii) a folder of notes about every patient who was considered to belong to the community psychiatric nurses' case-

load. These folders were kept in the nurses' office and were not available without special arrangements for other colleagues' use. They usually included a copy of any case-summary prepared by a psychiatrist when the patient was discharged from hospital. The nurses added progress summaries at intervals of six months or more, and copies of any correspondence of their own. Individual visits and other contacts were not recorded.

(iii) In some, but not all cases, progress summaries were contributed at irregular intervals to the hospital case-notes. These were available to other professional staff concerned with the case.

(iv) running records of injections (or other treatments) were maintained using charts and cards.

The nurses had no regular secretarial service or facilities for dictation. Case-notes were drafted in manuscript; copy-typing was available from time to time. Communication with colleagues in and out of the hospital tended to be by word of mouth.

Research Activities

This category denoted time given to completing the diary sheets for this study, and to any necessary discussion with the researcher.

Travelling etc.

This item covers the time spent on car journeys in the course of the day's work (not to and from home) and on the maintenance of the vehicle in running order - buying petrol, for instance, and dealing with the problems and emergencies which beset those who depend on motor transport for their work. The nurses used their own cars for their work and received a mileage allowance towards the costs incurred.

At the time of the field work for this study, patients living in all parts of the city were accepted by each of the parent hospital's clinical teams. Each of the nurses might therefore have referred to her, by her particular clinical team, patients who lived all over Edinburgh. It was considered more important to maintain close working relationships between the nurse and the teams to which they were attached, than to make marginal savings of time and

mileage by organizing their work on a territorial basis.*

'Providing transport' was originally recorded separately in order to find out how far transporting patients and others affected the nurses' working time and mileage. As this item did not appear to add significantly to the nurses' journey times, in the analysis it has been included under the general heading of 'Travelling'.

* The clinical teams were already beginning to develop links with particular areas of the city ('sectorization'). This process, which has since been taken further, should eventually produce a situation in which nurses are working in more limited areas.

6.3 Findings

In general terms, one-fifth of the nurses' working hours were spent with patients and families, a fifth in travelling, a quarter on office work, and a third on meetings, clinical discussion and liaison work. The proportion of time allocated to the various categories of work is shown in Table 6/1 and, in diagram form, in Figure 6/1.

TABLE 6/1

ALLOCATION OF NURSES' WORKING TIME TO WORK CATEGORIES

Category of work	Percentage of working time
Visits: actual	17%
abortive	1%
Injection clinic	4%
Clinical discussions	9%
Clinical meetings	14%
Accommodation liaison	1%
Other meetings etc.	6%
Office work etc.	22%
Research activities	3%
Travelling etc.	21%
Other/not recorded	2%

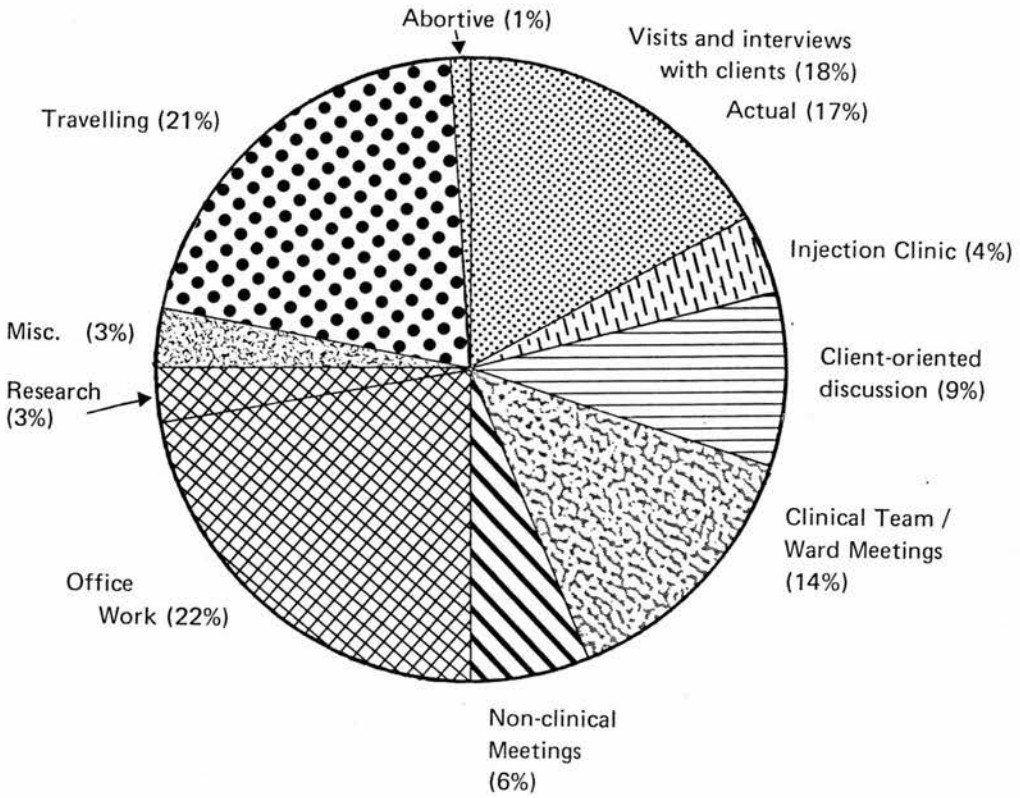


FIGURE 6/1. ALLOCATION OF WORKING TIME

Duration of main categories of work

More than half of the community psychiatric nurses' time was spent within the premises of the parent hospital.

TABLE 6/2

LOCATION OF NURSES' WORK

PROPORTION OF WORKING TIME IN RELATION TO LOCATION

LOCATION	PERCENTAGE OF TOTAL WORKING TIME
Within hospital premises	57%
Outside hospital premises	21%
Travelling	21%
Not recorded	1%

esults are shown in greater detail in Annex 6 (Table A6/1 to A6/5)

Contact with Clients[Ø]

There was a marked disparity between the duration of nurse/patient contacts at the injection clinic and nurse patient contacts in other settings. The average (median) duration of non-clinic contacts (3% of which were located on hospital premises) was 20 minutes (Table A6/3) whereas at the clinic the median duration of contact was only

Ø For comparison some findings from other studies of domiciliary nursing services are given here. In her study of Home Nursing in Scotland, Carstairs (1966) found that the mean length of all "Home Nursing visits" was 20.3 minutes. "Health Visits" (which included visits to the elderly at which no specific activities defined as 'nursing' care were carried out) were shorter - mean duration 15.5 minutes. 'Casual' visits were shorter than planned nursing visits but longer than 'Health Visits'. Describing the work of Health Visitors in one English county, Clark (1973) found that 51% of visits lasted between 15 and 30 minutes, and only 20% for more than half an hour. The majority of visits (80%) were planned. Unplanned visits tended to be shorter than planned ones. Potter and Hockey (1976) analysed the work of enrolled and registered district nurses in England in 1970. When the figures are re-calculated on the basis used in the present study (i.e. excluding meal-breaks and off-duty time from total working time), the proportions of working time occupied by patient care and contact were 52% and 51%, and by travelling 26% and 25%. The median duration of patient contacts was between 20 and 24 minutes for SENs and 15 and 19 minutes for SRNs. 18% of all patient contacts lasted 15-19 minutes and 15% 20 - 24 minutes.

3 minutes (Table A6/5). Data about sample patients (see Section 7, Table 7/2)shows that 41% of nurse-client contacts took place at the clinic; by contrast, attendance at the clinic occupied only 4% of the nurses' time. Less than 25% of nursing time at the clinic was spent actually conversing with patients (Table A6/4).

There was a wide variation in the duration of contacts both at the clinic and elsewhere (Tables A6/5 and A6/3). Clinic contacts ranged between 5 and 18 minutes; elsewhere the shortest and longest contacts which took place ranged from 4 minutes to over $3\frac{1}{2}$ hours. At the clinic more time on average was spent with patients who came towards the end than at the beginning of each session.

The ratio between planned or routine visits, and unplanned or crisis visits was 4 to 1. One call in six was abortive. Non-routine or crisis visits tended to take longer than planned or routine calls. Abortive visits were not in themselves time-consuming, but they constituted about 17% of the total number and must have added considerably to travelling time.

Meetings, Discussions and Liaison Work

The time spent at meetings was about equal to that spent in face-to-face contact with patients (Table A6/1). Virtually all the formal meetings attended, as well as 90% of informal discussions, took place within the hospital (Table A6/2).

Finding accommodation etc.

Activities in this category during the record period only occupied 1% of working time.

Social clubs etc.

No attendance at any social club or voluntary organization was recorded during the study period.

Office work

Office work was the most time-consuming single type of work. The records kept for this study added to the burden to the extent of 3% of working hours i.e. about 15 minutes a day.

Travelling

Data not reproduced in this report on the location of the nurses' work day by day, and by individuals, showed that each of the five nurses visited virtually every area of the city of Edinburgh during the two record weeks. Travelling time exceeded the total spent in contact with patients.

6.4 SUMMARY

The structure of the nurses' working day, as shown by the time spent on various types of activities and by their location, was studied by means of diaries. About 40% of working time was spent outside the hospital, approximately half in travelling and half on client contacts. The time spent within the hospital was divided between meetings and discussions (about 30%), office work (about 25%), and conducting an injection clinic (4% of working time).

SECTION 7

PATTERNS OF WORK: NURSES' CONTACTS WITH PATIENTS

The data reviewed in this section relate to a sample (see Section 4, p 87) of 154 patients (or 'cases'). 801 contacts with these patients or their families were recorded by the participating nurses during a period of four months (the 'sampling period'), 1st September 1972 to 31st December 1972. The sample comprises 50% of the nurses' case-load during the period. As it appeared that the sample was representative of the nurses' clientele, it was assumed also that these contacts were a representative sample of the nurses' work with clients during the sampling period.

The instrument used was the contact record schedule (Annex A4/3.1) which showed some features of the contact - viz: when and where it took place, who was present, who had proposed or prompted the contact, and whether the nurse noted any marked change in the condition or circumstances of the client (patient or family member) or any special cause of stress. The researcher also knew from other sources the patient's current status in relation to the parent hospital (out-patient, in-patient, day-patient etc.), and whether a depot phenothiazine drug had been administered. Data derived from interviews with the nurses and from patients' case notes is also used in this section (see Annex A4/4.1 and A4/4.2 about the referral of cases).

Information about contacts was analysed in two ways: firstly, it was used to illustrate the work situation of the nurses and the service as a whole. This is the perspective taken in the present section of this report. Secondly, the data were analysed by cases, so as to show the pattern of contact in relation to particular patients and families, and the type of care given in individual cases. The results of this analysis are considered in the following section (Section 8). Further information about what took place at nurse-client contacts - the "content" and "process" of the interaction - is considered in Section 9.

7.1 Findings

Number and sources of cases

The number of cases in the sample was 154. Individual nurses came into contact with between 79 and 101 cases during the sampling period; the mean number of cases per nurse was 89 (58% of the total sample).

34 new cases and 13 old cases were referred or re-referred to the community psychiatric nursing service during the sampling period.

Information was sought about referrals to the service which had taken place up to 12 months before the patient's 'key contact'. Almost all referrals (93%) were made by staff of the parent hospital, in most cases (76%) by a psychiatrist or collectively by a clinical team. Very few cases were referred from 'community' sources:

TABLE 7/1

SOURCES OF PATIENTS' MOST RECENT REFERRAL TO THE COMMUNITY PSYCHIATRIC NURSING SERVICE.

(percentage and number of cases)

Referral source	%	(n)
Staff of parent hospital:		
Clinical team (by group decision)	14	(18)
Psychiatrist	62	(77)
Nurse	17	(21)
Staff of other hospitals	3	(4)
General practitioner	2	(2)
Patient/relative/friend	2	(3)
	100%	(125)

NOTE: Information not known or not certain in 29 cases.

No direct referrals were received from social work staff (though the latter may have participated in clinical team decisions about referral). Most of the cases (17%) referred by nursing staff of the parent hospital were ex-patients who had returned to a hospital ward for maintenance injections until their care was transferred to the community psychiatric nurses at the injection clinic.

Community visits and clinic attendances

Nine out of ten of the contacts in the sample series took place either at the patient's home or at the injection clinic:

TABLE 7/2

LOCATION OF NURSE-PATIENT CONTACTS

(Percentage and number of cases)

Location	%	(n)
Patient's residence	50	(400)
Injection clinic	41	(327)
Elsewhere at hospital[ø]	5	(41)
Community location - other	3	(24)
Telephone contact	1	(9)
	100%	(801)

"Other" community locations* are included (together with contacts at the patient's residence and contacts by telephone) under the general heading of 'Community visit' in the tables annexed to this section.

Some features of community visits, clinic contacts, and other contacts on hospital premises were compared (viz: the initiator of the contact, the patient's current status in relation to the hospital,

ø "Elsewhere at hospital" included 16 events at which the nurse brought a patient from home to hospital (e.g. for a bath, to see a psychiatrist).

* Instances of "Other community locations" were: relative's home, patient's place of work, prospective lodgings, general hospital ward, nurse's car, day nursery, day centre, police station, in the street.

the frequency of contact in different locations, the number and type of clients and staff present in different locations). Results are given in detail in Annex 7, Tables A7/1 to A7/6. Most of the differences were inherent in the situations. The outstanding instance was, of course, the administration of depot phenothiazine injections.

TABLE 7/3

ADMINISTRATION OF DEPOT PHENOTHIAZINE INJECTIONS

BY LOCATION OF CONTACT

(number of contacts)

Location of contact	Injections given or due		
	Yes	No	
Injection clinic	(326)	(1)	(327)
Hospital (elsewhere)	(7)	(34)	(41)
Community visit	(61)	(372)	(433)
	(394)	(407)	(801)

Initiation of contacts was a further example of a feature largely determined by the situation; clinic attendances depended on the patient's willingness to exert himself, whereas community contacts were generally initiated by the nurse (Table A7/1). The proportion of community visits initiated by psychiatrists was about one in ten.

38% of the patients seen at community contacts were currently receiving no other care from the parent hospital than the nurse's visits (Table A7/2). Table A7/3 shows that community visits were more likely than clinic attendances to be followed up after a relatively short interval, and that changes in patients' circumstances such as admission to hospital were more often preceded by a community visit. (Non-attendance at the injection clinic was often investigated by a home visit).

Other points of contrast between clinic and home situations seem almost too obvious to need mention. At the clinic the patient

becomes one of a group who have equal status in relation to each other but who are all relatively dependent upon the nurses who establish the conditions - where, when and how - of the clinic sessions. The nurse however is not free to refuse access to the clinic to any bona fide patient who presents himself. At home visits some aspects of this situation are reversed. The nurse is generally present on her own initiative, not at the patient's request (see Table A7/2). The patient and his family are not bound to accept her services or to receive her into the house. The nurse lacks control over the situation and must adapt her approach to her status as a guest. She lacks the immediate support of institutional and hierarchial structures and often works in isolation.

People present at nurse-patient contacts

The 'mix' of professionals and clients present at community and clinic contacts differed. At the clinic, there was little variation, the group consisting almost invariably of the patient and two community psychiatric nurses (Tables A7/4 and A7/5).Ø There was very little participation by other professional colleagues in patient-nurse contacts at the clinic; the only type of staff who took any part were the psychiatrists (at 4 out of a total of 327 clinic contacts). The possibility for patients to consult a psychiatrist at the clinic was much greater than this figure suggests, and certainly greater than in the community situation; the reason for the apparent absence of psychiatrists was that, at this time, doctors in attendance at the clinic generally saw patients apart from the nurses, and thus were not recorded as taking part in nurse-patient interaction. For comparison, a list of services in touch with clients, and the extent to which the community psychiatric nurse reported contact with them, is available at Table A7/7.

The total number of people present at community visits was seldom large, only 6% of such visits (26 events) involving more than four persons. (On one occasion, by contrast, the presence of eleven people was recorded).

Ø At this time the clinic was conducted by two community psychiatric nurses without other assistance

The community psychiatric nurse saw one person only at 55% of community visits (231 events). 32% of community visits (137 events) involved a conjoint family interview - that is to say, a group including the identified patient and one or more relatives.

Conjoint interviews took place at 18% of all contacts in this series (147 events). Most often the patient and one relative were seen together. The numbers in family groups ranged from two to seven, and their frequency was as follows:-

Patient and one relative	102 contacts
Patient and two relatives	31 contacts
Patient and three or more relatives	10 contacts

More often than not the group included two generations (83 contacts); three generations were represented on four occasions. The relationships of others in the conjoint groups to the identified patient were as follows; (the numbers total more than the total number of conjoint groups because on some occasions more than one of these categories of relationship was represented):

TABLE 7/4

LIST OF RELATIVES SEEN WITH IDENTIFIED PATIENT AT CONJOINT INTERVIEWS

Relative	Conjoint Interviews	
	%	(n)
Mother only	9%	(13)
Father only	1%	(2)
Both parents	3%	(4)
Spouse	19%	(28)
Child(ren)	46%	(67)
Sibling(s)	13%	(19)
Other relative or household member	18%	(26)

A community psychiatric nurse was the sole professional worker present at 66% of these conjoint family interviews.

The smallest possible 'group', a dyad consisting of a community psychiatric nurse and one patient or client, met at 39% of the contacts in this series (308 events). On 281 occasions the nurse saw the identified patient alone, and on 27, a family member alone. The family members bore the following relationships to the identified patients: mother (7), father (2), spouse (13), child (4), other household member (1)

Detection of change or stress

Nurses were asked to note on the contact record schedule any marked change in the patient's condition, either for better or for worse, which they noticed, or any new source of stress. The data on contacts was examined to see whether any response in terms of the frequency of visiting could be found. A distinct response was evident, in that the interval before the patient's next contact with the service tended to be significantly shorter:

TABLE 7/5

INTERVAL BETWEEN CONTACTS IN RELATION TO THE NURSE'S OBSERVATION OF STRESS

(number of contacts)

Duration of interval	Stress		
	Present	Absent	
13 days	50	210	260
14 - 27 days	12	322	334
28 days	13	134	147
	75	666	741

X^2 35.01, 2 d.f., $p < 0.01$

TABLE 7/6

INTERVAL BETWEEN CONTACTS IN RELATION TO THE NURSE'S ASSESSMENT OF THE PATIENT'S CONDITION

(number of contacts)

Duration of interval	Patient's condition			
	Worse	No change	Better	
13 days	48	201	11	260
14+days	33	431	17	481
	81	632	28	741

X^2 23.81, 2 d.f., $p < 0.01$

7.2 SUMMARY

In this section data were presented relating to the place of nurse-client contacts in the work of the community psychiatric nursing service as a whole. Some information was also given about the sources from which the service obtained its cases, and the extent to which it worked with other disciplines and agencies.

Two types of situation in which 95% of contacts took place - the nurses' injection clinic and "community visits" - were compared. These situations were differentiated in terms of the initiation of the contact, the type of care given, the people present and the social roles played by nurses and clients. Analysis of the client group showed that conjoint interviews including the identified patient and his relatives took place at one-third of community visits, and that two-thirds of these were handled by a community psychiatric nurse as the sole professional worker. Work with spouses was important both in conjoint and individual interviews.

Nearly all referrals were received from sources in the parent hospital - specifically from psychiatrists and clinical teams. Referrals by and joint visiting with community-based health and social work staff were very infrequent. An apparent lack of collaboration with social work staff, both within or outside the hospital, was particularly noted.

SECTION 8

PATTERNS OF CONTACT:

PATIENTS' CONTACTS WITH

THE COMMUNITY NURSING SERVICE

Records of contacts with patients and relatives were kept by the participating nurses throughout the sampling period. Recording was then continued for a further two months (the 'follow-up period') in order that the frequency of contact with cases referred late in the sampling period could be assessed.

In Section 7, features of contact events in general were discussed. This section concerns contact, in individual cases, with patients and relatives; it deals with such questions as how often, where, and with what degree of consistency these contacts took place.

Before the data on contacts could be analysed case by case, it was necessary for information relating to individual cases to be sorted and summarized. The necessary manipulation of the data was carried out on the computer by means of programmes written for the purpose by staff of the Edinburgh Regional Computer Centre. This analysis related only to the sample of 154 patients; thus it was possible to relate data about contacts to other information about each patient and his circumstances supplied by participant nurses at interviews.

The full range of information was however only available in 111 cases. In a substantial proportion of cases (28% or 43 out of 154), interviews were abandoned because the nurse knew too little about the patient to be able to answer questions about home circumstances and personal problems, or to assess the patient's behaviour. These cases fell into two groups:

(1) The first type (21 cases) were people who regularly attended the injection clinic and had never been visited at home by the nurses. Some of this group were seen periodically by a psychiatrist or psychiatric social worker, and were considered by the community nurses to be primarily in the care of this colleague. Others were

hospital in-patients resident in a ward or rehabilitation hostel. Five of the group were first referred to the clinic during the study, the rest were regular attenders throughout the period. Together they accounted for 155 contacts during the study period, 13% of the total recorded for the whole sample.

(ii) The second type (22 cases) consisted of patients who had only been in contact with the service once, and who were not expected to need further attention, at the time of the first research interview. In 18 of these cases the nurse had been asked to carry out a specific task as an agent of the hospital or of one of its staff; these tasks ranged in magnitude from delivering a message or a day's supply of drugs, to finding, persuading and escorting to hospital a severely disturbed absconder. In the remaining 4 cases the referral to the service had proved unsuccessful, either because the patient left the Edinburgh area, or because he refused the nurse's attention. In the upshot a few of these patients were seen more than once during the study, but it was not attempted to complete the research interviews outside the normal sequence. This type of case accounted for 37 contacts during the study period - about 3% of the total number for the whole sample.

8.1 FINDINGS

Duration and continuance of care

A substantial proportion of the sample clientele (approximately a quarter) had been in touch with the service for two years or more at the time of the patient's key contact. About half of the case-load were referred during 1972, the year of the study (Table 8/1).

More than half of the sample had been continuously in touch with the service since their first contact (Table A8/1). Newly referred cases were relatively less likely to lead to continuous care: Table A8/2 shows that about two-thirds of the sample cases referred or re-referred during the study did not lead to continuous care.

TABLE 8/1

DATE OF PATIENTS' FIRST CONTACT WITH THE COMMUNITY PSYCHIATRIC NURSING SERVICE.

(Percentage and number of cases)

	%	(n)
1970 or before	22	(34)
1971	29	(44)
Jan. - August 1972	23	(36)
Sept. December 1972 ('Sampling period')	22	(34)
Not known	4	(6)
	100	(154)

Interruption or termination of service

As there was no recognized procedure for closure or termination of cases by the nurses, it would sometimes be difficult to say whether a case had been closed or was in abeyance. The community psychiatric nurses reviewed their case-load from time to time and would indicate to each other that such-and-such a patient was no longer being visited or did not need to be seen again. These decisions did not appear to be discussed with any regularity with any other person, or notified either to the patient's general practitioner or on the hospital case-notes. Not infrequently, in cases of longer standing, there would be no member of the nurse's clinical team, apart from herself, who was acquainted with the case.

Some enquiry was made about reasons and procedures for termination in cases which were closed (or interrupted) during the study period. At the end of the study, 34% of the sample cases (52) were no longer in the care of the community psychiatric nursing service. 38 of these had been in their care for less than a year - 23 being referred during the

sampling period and 15 in the earlier part of 1972. 17 of the 52 cases were referred only for some ad hoc form of service. 15 were admitted as in-patients before the end of the study, and 1 was a day-patient; these might return to the care of the community psychiatric nurses. In the remaining 19 cases the reasons for termination were as follows:

The patient refused or evaded the nurse's care - 7 cases

The patient moved out of Edinburgh - 3 cases

The nurse considered the patient sufficiently improved or adequately supported from other quarters - 4 cases

The nurse did not think that further work would serve any useful purpose - 5 cases.

Cases in which the patient was receiving depot phenothiazine injections were significantly less likely to have been interrupted than those in which other types of medication were prescribed (Table A8/3).

27% of the sample (42 people) were admitted to or discharged from hospital (or both - 28 cases) at least once during the 6-month study period. 6 people were discharged without being re-admitted; 26 were admitted once and 10 more than once.

Frequency and location of patient - nurse contact

It seemed likely that the place where most contacts took place and the frequency of contact, in any particular case, would be related to such characteristics of the patient as his sex, age, diagnosis, mode of treatment, level of mental and behavioural disorder, and other features. An analysis was carried to see whether these variables were related.

It was assumed that the frequency of contact might be taken as an indication of the amount of attention which each case received from the nurses. It was first necessary to devise a way of measuring frequency. The total number of contacts per case varied from 1 to 36, with a median value of 7. However, since patients were in the care of the service for varying lengths of time during the study (Table A 8/4), the number of contacts in any particular case is not in itself a good indicator of the amount of attention

received by the patient. An index figure was therefore calculated for each case, to give a rough-and-ready indication of the frequency of contact; the index was obtained by dividing the total number of contacts for the case by the number of study weeks during which the patient had been in the care of the service. Thus, a patient visited once a fortnight for 26 weeks would have an index of 0.5; another seen 5 times in 22 weeks would have an index of 0.23. The distribution of index numbers in the sample is shown below: the median frequency corresponds to one contact every three weeks.

TABLE 8/2

FREQUENCY OF PATIENT - NURSE CONTACT

(percentage and number of cases)

Index of frequency[2]	%	(n)
Low (≤ 0.25)	22	(30)
Medium ($> 0.25, \leq 0.65$)	57	(78)
High ($> 0.65, < 1.50$)	17	(24)
Very high (≥ 1.50)	4	(5)
	100	(137)[1]

Median index = 0.35 Mean = 0.44

Notes: (1) Excludes cases where patient seen once on agency basis

(2) Low frequency = up to 1 contact per 4 weeks

Medium frequency = more than 1 contact per 4 weeks and less than 2 contacts per 3 weeks

High frequency = from 2 contacts per 3 weeks to less than 3 contacts per 2 weeks

Very high frequency = equal to or more than 3 contacts per 2 weeks.

The index number is superior to the absolute number of contacts as a measure of the amount of attention given to or demanded by an individual and his family; but it has drawbacks in confusing two types of event that are so dissimilar as clinic attendances and home visits. In fact, patients who were only seen at the clinic seemed to form a distinct group from those who were always visited at home. A third group, the 'irregular attenders', were seen both at the clinic and at home (or elsewhere 'in the community'). The size of these groups was as follows:-

TABLE 8/3

Classification of cases by major location of contact

(number of cases)

Clinic attenders only	36 cases
Community visits only	42 cases
Irregular attenders	36 cases
Others (e.g. home and hospital contacts)	40 cases
	154 cases

The obvious factor which distinguished the clinic patients from the others was the fact that the former were all receiving similar treatment, which was shared by only some of the latter. It follows that characteristics associated with injection treatment should also be prominent among clinic patients. Depot phenothiazines were predominantly prescribed for schizophrenic patients, and in the group of patients studied there was a higher incidence of schizophrenia among patients under 55. As expected, therefore, a high proportion of clinic attenders were diagnosed as schizophrenic, were aged less than 55, and had other characteristics associated with a diagnosis of schizophrenia, or with younger age - for instance, a history of multiple admissions to psychiatric hospitals and a relatively consistent record in employment.

A characteristic of people who were seen sometimes at the clinic and sometimes elsewhere, was a significant tendency to show behaviour disorders. No difference in the severity of mental symptoms was however apparent between this group and other patients.

Injection therapy, by virtue of the regular intervals at which it needed to be given, had the effect of regulating the occurrence of contact with the community nursing service. Clinic patients were in contact with the service less frequently on average than home patients. The frequency of home patients' contacts was much more often found at the extremes of the range - that is to say, it was home patients who were seen either very frequently or very seldom, whereas the pattern of contact at the clinic was of moderate frequency. Patients who were seen both at the clinic and elsewhere had contacts at a frequency intermediate between the home and clinic groups (mean value of the frequency index number for the intermediate group was 0.48). The distribution of index numbers in the home and clinic groups is compared in the following table:

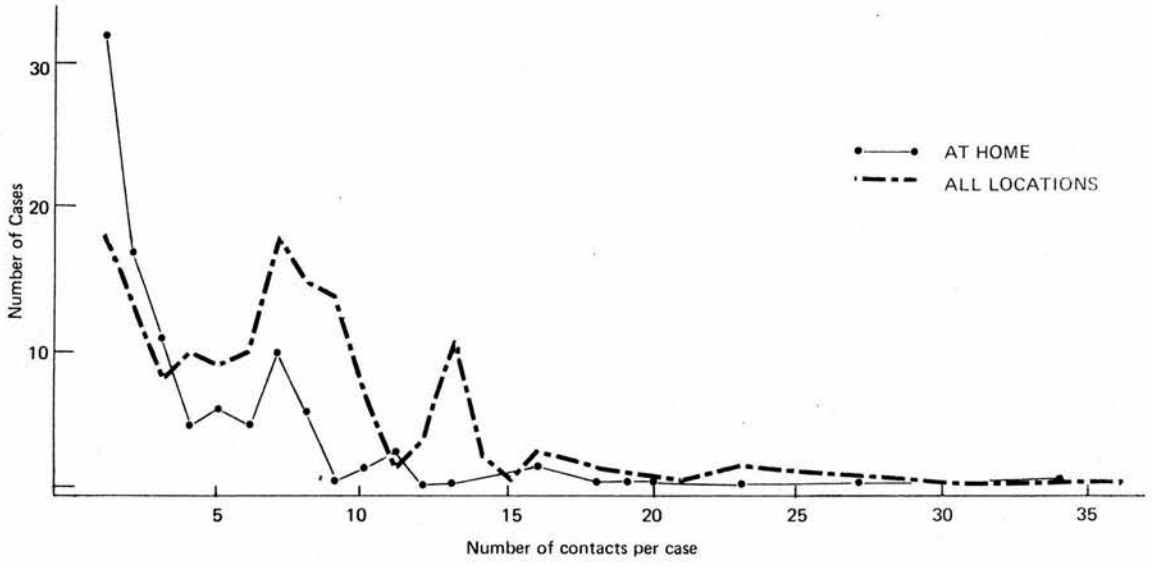
TABLE 8/4.

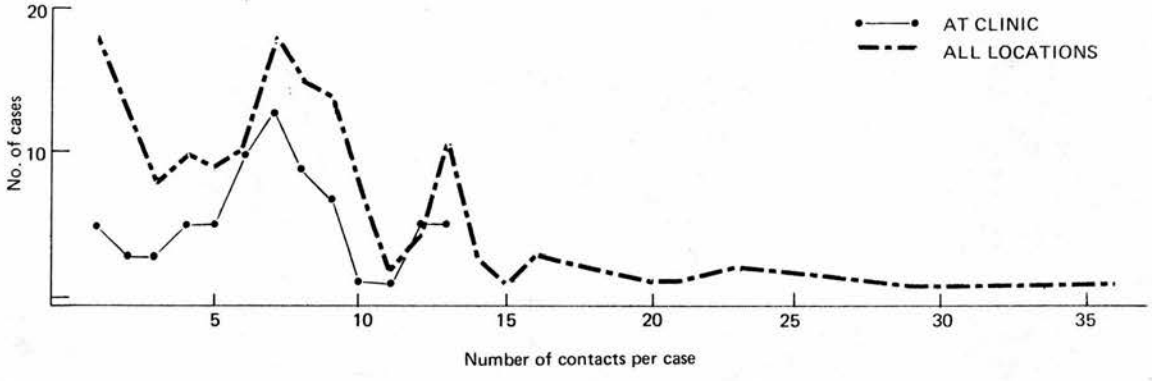
INDEX NUMBERS (FREQUENCY OF CONTACT)

	Clinic patients	Home patients
Mean value	0.35	0.57
Minimum value	0.15	0.04
Maximum value	0.67	5.00
Standard deviation	0.36	0.90

Figure 8/I, comparing the overall number of contacts for each patient with the number in clinic, home and other settings separately, shows the same relationship. A high number of contacts was associated with home care, and a medium number with clinic attendance.

It was found that people to whom a diagnosis of schizophrenia was attached were significantly less likely than others to have high indices for frequency of contact; also that younger people were less likely





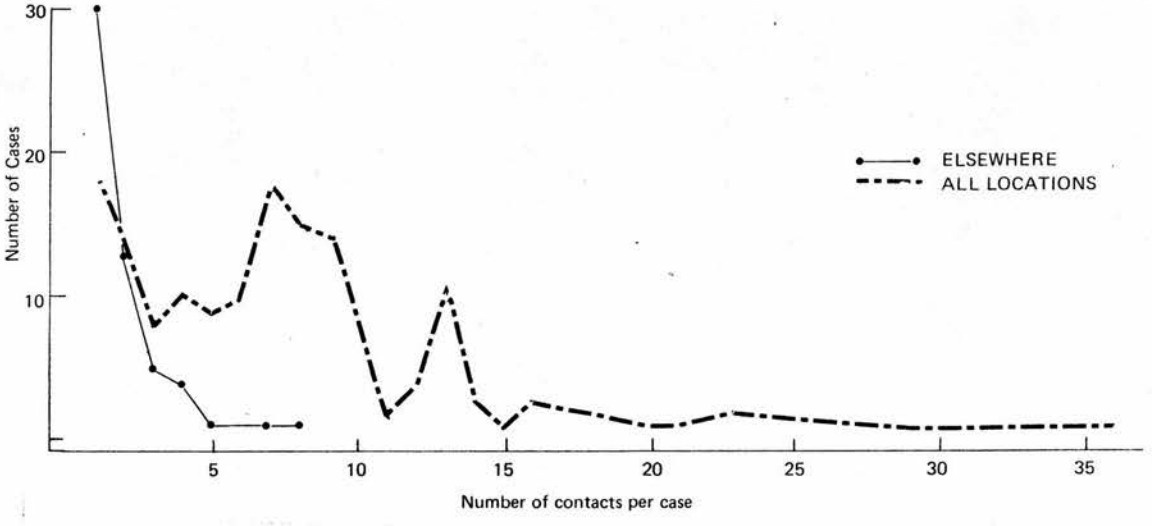


FIGURE 8/1. LOCATION OF CLIENTS' CONTACTS WITH THE SERVICE: HOME, CLINIC & OTHER LOCATIONS.

than older patients to have low index numbers. These apparent relationships between age, diagnosis and the frequency of contact were probably due in fact to the patient's treatment regime, because of the associations which existed between age, diagnostic category and treatment.

Contact was more frequent in recently referred cases: there was a highly significant association (Table A8/5) between a high index of frequency of contact, and relatively recent referral to the service. There was also a trend, which did not reach significance, towards association between higher index numbers and recent discharge from hospital (within 6 months before the key contact). No association was found between the number of psychiatric admissions before the key contact and the frequency of contact.

The only other factor which seemed connected with frequency of contact was the nurse's assessment of the patient's behaviour and mental state. High frequency of contact was significantly more likely in cases where the nurse rated the patient as handicapped in any degree by his mental condition, or as showing a moderate or severe degree of behavioural disorder. Observation by the nurse of actual social isolation or of feelings of loneliness on the patient's part was not associated with any difference in rate of contact; nor was any personal characteristic of the patient such as sex or social class.

Contact with Individual Nurses

Consistent personal contact between psychiatric patients and individual nurses is widely regarded as a desirable characteristic of psychiatric nursing care, both because it enables the nurse to use her personal relationship with the patient for his therapeutic benefit, and also because her experience of his previous reactions help her to understand and interpret his current behaviour (cf Kirkpatrick 1967). Harries (1972) suggested that continuity in nursing care is achieved by teamwork on the part of successive relays of nurses and that personal continuity is not a characteristic attribute of psychiatric nursing care. Altschul (1973) found, in a study of extramural treatment by multi-disciplinary teams, that personal continuity was achieved in all teams, but became the particular responsibility of

the nurse in those teams that included a full-time community psychiatric nurse.

In this study, 44% of sample patients met one particular nurse at every contact during the study. In 95% of cases one individual nurse was involved with some regularity - viz: at more than half of the contacts recorded with the patient. The experience of the sample patients in respect of consistent personal contact with an individual nurse depended on whether they were seen only at the clinic or on the other hand only elsewhere (particularly at home). Few patients visited only at home met more than two of the five community psychiatric nurses, and few clinic attenders met less than four of them during the study (Table A8/6). The commonest experiences were to come in contact either with one nurse (29% of cases), or with all five of them (25% of cases).

8.2 DISCUSSION

Some ways in which clinic attenders' care differed from that offered to home clients have been mentioned in this section; they included differences in duration and frequency of care, and in the possibility of a special relationship with a nurse. Domiciliary visiting provided, in a high proportion of cases, consistent attendance by one particular nurse - a more personal and patient-oriented form of care than was afforded by clinic attendances; this difference was also shown in the much greater amount of time spent in contact with clients at home visits (Section 6). Other contrasts between the two situations and in the range of people involved were discussed in Section 7. The domiciliary situation provided opportunities for observation of and intervention in family relationship and other problems and for counselling and supportive work with patient's relatives which were not available at the clinic. It was evident from the fact that little was known by the nurses about some of the regular clinic attenders that, compared with home visiting, clinic practice provided a very restricted range of data on the patient's behaviour and social circumstances, and a less than satisfactory basis for clinical or social assessment.

The clinic system provided a remarkably smooth and economical way of maintaining a limited form of medical treatment, moderate in frequency and far more regular and predictable than the general run of domiciliary care, but completely dependent on the patient's regular attendance. Patients who attended the clinic were likely to be more homogeneous, in terms of their treatment and diagnosis, than people seen at home only. Clinic patients tended (predictably) to be younger and more mobile, and (less predictably) showed a higher incidence of disturbed behaviour than home patients. There was some indication, too, that irregular clinic attenders may have differed in specific ways from regular attenders; time was not sufficient to pursue this point which could be more adequately investigated in a study focussed on patients and patients' careers.

At the time of the study, home or clinic care was selected on a basis of trial and error, or for the convenience of the patient or the nurse. If it were possible to identify types of patient for whom one or other form of care was likely to be more suitable, and to define indicators of these types, then assignment to home or clinic care could be made on a more rational basis.

8.3 SUMMARY

This section deals with the experience of the patient or client in contact with the service. Two distinct groups of patients were identified - those who always attended the injection clinic and were never seen elsewhere, and those who were always seen at home. These groups were found to differ significantly in some respects. The characteristics of intermediate groups who received mixed forms of care were not fully investigated. Some features of home visiting and clinic treatment were contrasted. It was suggested that indicators for the use of domiciliary or clinic care should be sought so that rational assigments may be made to them.

Frequency of contact in individual cases was also examined. Patterns of contact were found to be associated with some aspects of the nurse's perception of the patient.

SECTION 9: NURSES' ACTIVITIES AT CONTACT BETWEEN NURSE AND CLIENT

One of the objectives of the study was to describe nurses' activities in relation to patients and their families, in order to identify the techniques and skills which they employed. This section deals with an attempt to ascertain, in some detail, what nurses looked for, talked about and did when they were in personal contact with patients and their families in 'community' situations. The aim of this part of the enquiry was to show the prominence of various types of activity and concern in the nurses' work, and to indicate how they were interrelated. It was thought that the results should give some indication how far nurses were concerned with specific, medically-oriented tasks and observations, in comparison with psychotherapeutic functions. In the latter context, it was hoped to show how far the nurses used a dynamic model of intervention, aimed at changing behaviour through developing insight and understanding of personal and inter-personal factors; and (bearing in mind suggestions in the literature that nurses tend to be directive and authoritarian in their dealings with patients) to show how far they relied on the use of personal and professional authority. It was also hoped to indicate how far modes of practice were related to certain characteristics of patients or situations. No specific hypotheses were propounded or tested, but it was expected that the findings might suggest questions for further investigation.

9.1 Method of Enquiry

It was decided at the outset of the study to rely on self-reporting methods rather than on participant or non-participant observation in the contact situation. The arguments for and against observational methods have been reviewed in Section 4. In connection with this particular phase of the study, the main disadvantage of such a method would have been the introduction of bias, owing to the observer's presence, both in the range of events available for observation, and in the behaviour of nurse and client. In addition, observation tends to direct attention to discrete items

of overt activity and to divert it from the meaning of the activity for the participants.

The use of tape-recorded transcripts of interviews to secure unbiased records of nurse-client interaction was considered; but this method would,if anything, have increased the problems of interpreting the material. Moreover, very sophisticated apparatus would be needed to record community contacts which might involve suspicious, restless or uncommunicative people, and might take place through letter-boxes, on park benches or against a background of domestic noises. The practical problems of this method seemed insuperable, and the time required for transcribing and coding recorded material was not available.

Self-reporting, assuming that each of the five nurses contributed a sample of contact records, would introduce and confound five different types of personal bias. It would have the advantage however of making available a representative sample of events. Though the method would not be objective, the results could be regarded as a fair indication of the nurses' perceptions of what they did (or intended to do). It was decided therefore to develop a record schedule which the nurses could complete at a series of contact events. To equalize the amount of bias due to the five participants, an equal number of contact records (100) would be obtained from each of the five nurses. The average number of nurse-client contacts observed in the diary investigation (section 6) was 15 per week. On this basis a series of 100 contacts was expected to be completed by all nurses in about 7 weeks. (In the event one nurse took 6 months to complete the series).

It was decided to restrict this enquiry to home and community visits and to exclude contacts at the injection clinic. The 'activity schedule' was attached to the contact record schedule (Annex A4/3.1), and the nurses were asked to complete both schedules in respect of every contact with a client (patient or relative) from the beginning of the study period. Each nurse completed her series of 100 activity schedules at a different date. After doing so, she was asked to complete contact record schedules only for each contact up to the end of the study period.

9.2 Development of the research instrument

No existing classification of psychiatric nursing activities which was apposite to the aims of this enquiry was found in the nursing literature. Categorizations of psychiatric nursing 'skills' and 'functions' were too general and abstract (e.g. the WHO classification - WHO 1963 - mentioned on p. 49 above). Most of the existing observational studies of psychiatric nursing were designed to be carried out in ward situations, and were unduly concerned with the performance of specific tasks (Goddard 1955, Oppenheim and Eeman, 1955), or with a particular aspect of nurse-patient interaction (e.g. Hargreaves and Runyon 1969). In several American studies variants of Bales' interaction process analysis had been used, but the categories did not seem relevant to the purpose of this study.

Studies in related fields were therefore examined. Previous investigations of district nursing did not prove useful because of their orientation to physical modes of care; but two recent studies of health visiting by Marris (1970) and Clark (1973) proved more helpful. Self-reporting methods were used in both of them. In an analytic description of health visitors' practice in Berkshire, Clark (1973) used a self-administered schedule on which were recorded, among other things, topics discussed at each interview, and the 'communication techniques' applied to each. Clark defined three types of communication techniques:

> listening and reassurance only
> discussion plus factual information
> discussion plus positive advice or teaching

These were related to categories of content or subject-matter.

In the present study it was decided to make the assumption that listening and talking were the principal means of communication in nurse-patient interaction, and to attempt a more precise description of the nurse's use of interpersonal techniques. Observation of psychiatric nursing practice showed that different types or aspects of activity could be discerned taking place simultaneously at different levels; the initial problem was to define and differentiate these aspects. In Marris' study of the work of health visitors in London, the respondents were asked to record several aspects of each

visit. The aspects defined were:

the nature of the visit or activity
the person or persons "served"
the topic or topics discussed
the techniques exercised.

"Techniques" included both manual and interpersonal skills (for instance "administering injection" and "relationship building")and, in addition, subsequent action (e.g. referral or consultation). The following aspects were abstracted from Marris' classification:

Activities ("What you did")
Techniques ("How you went about it")
Topics ("What you talked about")

To test their application to the situation of the community psychiatric nurse, each participant was asked to write two or three acounts of community visits under these headings. The accounts which this request elicited were full of vivid and idiosyncratic detail. They established to the researcher's satisfaction that free descriptions would produce date from standpoints so different that it would be impossible to find a coherent method of analysis. It was essential therefore to define a standardized descriptive framework. Marris' classification of three main descriptive levels or aspects was adopted but, as the nurses' accounts showed that a high proportion of the reported "Activities" had been concerned with observation of the patient or assessment of his situation, this aspect of the nurses' function was included as a fourth main category. These became, therefore:

Activities
Observation/Assessment
Interpersonal procedures
Topics

Specific descriptions of appropriate items of activity, observation and subject-matter (topic) were derived from the researcher's notes and observation, from the literature, and from participant nurses' written and verbal accounts of contacts. The schedule produced is to be found at Annex 4/3.2. Explanatory comments on the various items are to be found in Annex 4/3.3 (paragraphs 9 to the end).

Classifying the process of nurse-client interaction in terms of interpersonal techniques or procedures was a much more difficult undertaking. The nursing literature contained no suitable tool for the purpose, but Hollis' classification, which was found in the

literature of social casework, seemed to the research worker to fit the concepts and practice of psychiatric nursing, and to be capable of yielding material relevant to the concerns of the study.

Hollis' classification was developed through study and analysis of process records of client-interviews written by social workers in the United States (Hollis 1967a, 1967b). It was designed as a tool for comparing the efficacy of the various procedures in different circumstances and cases. Hollis maintains (1972, p. 77) that the classification deals solely with the methods or techniques used by the worker and not with their outcome. It has been found to be reliable and valid for the analysis of process records and verbatim transcripts of tape-recorded interviews (Hollis 1972 pp. 181-182), and has been applied as an analytic tool in several research studies of social work intervention.ø

Hollis' classification was adapted in several ways for use in this study. In the original summary terms, Hollis' categories are not easy to understand for those unfamiliar with the language of American social work. In order to make the individual items self-explanatory (as far as possible) to participants, they were translated and expanded in words which it was thought would be more familiar, drawing on Hollis' own explanations and illustrations. One item was restated in two parts, and two others were combined in one; these changes are discussed below in greater detail.

Borrowing from the literature of another discipline may require justification. It could be argued that activities whose surface appearances are the same acquire different meanings when they are performed in different contexts. This may well be so; but provided descriptive categories apply only to what can be objectively described, and do not impute added meanings, they remain valid in different contexts.

Three further arguments are advanced for making use of the Hollis typology; shared concepts, shared territory, and observed congruence or 'fit'. Firstly, psychiatric nursing and social casework both derive basic concepts and principles from psychodynamic theories as expressed in the practice of individual and group psycho-

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ø Seven such studies are quoted by Hollis (1972 p. 181-2). The typology was also used in a British study by Butrym (1968).

therapy. Secondly, inasmuch as both psychiatric nurses and social workers are concerned with disturbed social and family relationships and are engaged in "the therapeutic use of the self", they are operating in the same territory and relying on the same tools. Although the elements of therapeutic interaction may be differently deployed by different disciplines, the writer would argue that these elements are essentially the same for all the 'helping professions'. The third argument is simply that, in this writer's experience, Hollis' categories can and do describe a major part of the interpersonal aspects of psychiatric nursing practice as she has herself observed it.

The application of the classification to nurses' actual practice was tried out at various stages of its development, thanks to the cooperation of several nurses working in different localities. More extended trials of the later versions were carried out in Birmingham and Dundee, to show whether the categories were understood and how far they were being used. As a result five additional items were added to the six 'Interpersonal Procedure' categories derived from Hollis' typology, to give a more complete account of the principal methods used by nurses. Provision was also made for the participants to record responses in their own words, but little use was made of this opportunity during the study itself. Successive amendments were made to the instrument as a result of the trials, and it finally emerged as a check-list containing four groups of items, from which nurses were asked to tick those which applied to the contact they were recording. In addition the contact record (Annex 4/3.1) provided basic information about the circumstances of the contact, to which the activity items could be related.

9.3 Components of the instrument: discussion of terms

(i) Activities

This, the first group of items on the check-list, was intended to record work which entailed a specific motor activity or skill. It was arranged in four sections which were supposed to represent compensatory, rehabilitative, technical and regulatory activities on the nurse's part. This classification proved unsatisfactory and needs revision. The distinction between "Personal service"

(= compensatory) activities and "Joint" (= rehabilitative) activities could not be sustained in practice. A majority of the items recorded under both Personal Service and Joint Activities did not fit the sub-categories specified and were recorded under "Other". Judging from the activities specified by the nurses under "Other", no consistent distinction could be drawn between personal service and joint activities. The attempt to distinguish between these categories was seen to be ill-judged because it was not based on a descriptive classification but referred to the intentions of the nurse.

The item "Providing Transport" usually meant giving a lift to a patient, often taking an in-patient on a visit in preparation for discharge, or bringing an out-patient to the hospital for a psychiatric interview, a bath, or for assessment for day-patient care.

"Social Activities" generally meant accepting a cup of tea; sometimes it meant offering refreshment in a pub or cafe.

"Technical Nursing" activities denoted those for which specific training or knowledge were required. The activities described included administering drugs either by mouth or by injection, examining and advising on treatment of minor lesions or skin infestations, and giving advice about psychotropic medication to patients, families, or the staff of non-psychiatric hospitals.

"Regulation and Guidance" related mainly to the functions carried out in connection with psychiatric emergencies and the admission of patients to the parent hospital. "Tracing" patients was also associated with non-attendance at the injection clinic or for other types of out-patient or day-patient care.

(ii) Observation/Assessment

These items are self-explanatory. All of the items recorded under the heading "Other" were about some aspect of interpersonal relationships, usually in a family group; they were coded under the appropriate heading.

(iii) Interpersonal Procedures

Hollis' categories of helping procedures (which were the starting point for constructing this section) are as follows:

Sustainment
Direct influence
Exploration-description, ventilation
Reflective discussion of the person-situation configuration
Reflective discussion of the dynamics of response patterns or tendencies
Reflective discussion of developmental aspects of response patterns or tendencies

These descriptions were revised and reworded, as already explained, to make them more accessible to the users:

Sustainment: this was restated (using Hollis' own terms) as "The expression on sympathetic interest, reassurance, confidence or encouragement".

Direct influence: In Hollis' typology this category embraced the use of appeals to both cognitive and affective motives. To distinguish these different methods of exerting influence on the patient or client, this term was replaced by two items - "Advise, criticise, persuade or warn", and "Give information, explanation or instruction". The first item describes attempts to exert influence at an emotional level; the second connotes a teaching function or communication at a predominantly cognitive level.

Explorating-description, ventilation: Hollis' terms include the client's response as well as the worker's method. The item was re-phrased, in reference to the nurse's activity only, as "Allow or encourage ventilation or release of feelings".

Reflective discussion of the person-situation configuration: this rather obscure phrase was re-worded as "Encourage the client to think carefully about the nature or effects of his current situation and behaviour".

Reflective discussion of the dynamics of response patterns or tendencies:
and
Reflective discussion of developmental aspects of response patterns or tendencies: In Hollis' typology a distinction was made between two kinds of 'uncovering' or 'insight-directed' techniques. Such techniques are aimed at bringing to the conscious level sub-conscious or pre-conscious material. The distinction between dynamic and developmental aspects relates to the stage of personal development to which analysis and interpretation are

directed - that is to say, whether the focus is upon current intra-psychic and interpersonal mechanisms, or upon their origins in the individual's early experiences. For the purpose envisaged in this study, this distinction between 'dynamic' and 'developmental' modes of interpretation seemed superfluous; it was sufficient to find out whether the exploration or interpretation of pre-conscious material was attempted. A single category was therefore substituted: "Interpret to the client the origin or dynamics of his patterns of response and behaviour".

On the basis of the material examined during the development and testing of the check-list, five further categories were added to the Interpersonal procedures:

"Use systematic questioning to elicit specific information"
"Hold a friendly conversation on normal social topics only"
"Listen or respond to disturbed or delusional talk"
"Use an authoritative or directive manner"
"Offer practical assistance or referral to another agency"

Further explanation of these categories, and examples derived from nurses' descriptions of actual situations, were included in an explanatory memorandum (see Annex 4/3.3).

(iv) Topics

Topics without direct significance for the assessment of social or psychiatric status were not included. Each of the topics mentioned had been noted with fair frequency during the trial stages.

9.4 Methods of Analysis

The data consisted of dichotomous (positive or negative) reponses, equivalent to the answers "Present" or "Absent", to 55 items in the check-list. Responses entered under "Other" headings were assigned as far as possible to an appropriate category; if not they were ignored for most purposes of analysis. It will be seen that the number of responses so treated was small. Some categories in which there were few positive responses were combined with other related categories in the same main group; this applied especially to 'Activity' items. The revised total number of items was 42.

Computer analysis made it possible to calculate correlation coefficients between all the items on the check-list, to relate items to other features of the contact situation (recorded on the contact record schedule), and to examine their relation with characteristics of the identified patient.

The contributions of individual nurses were not analysed separately. The aim of the study was not to examine individual variations but to describe a service; moreover it was desired to avoid any possibility of individuals' work being identified. Only one exception was made to this principle: the mean number of entries per group of items was calculated for each participant to show the extent of variation between them. The results of this exercise showed considerable variation between nurses in the number of items recorded, particularly regarding "Activities" items. There was also a variation in the consistency with which individual nurses reported their own performance. These variations may have reflected differences in the practice of individuals in the contact situation, or merely personal differences in modes of perception and styles of reporting. The results are given in detail in Annex 9/1.

Fourfold-point coefficients of correlation (the 'Phi' coefficient) showed degrees of association between particular items, but did not indicate more complex relationships - that is to say, whether the items tended to occur in groups or 'clusters'. A method called 'Elementary Linkage Analysis' developed by McQuitty (1957) was employed for this purpose. As its name implies, it is the simplest of a number of methods of typal analysis developed by McQuitty. It can be used to cluster people, items or variables. The method is based on a theory of types, the principle being that every member of a type is more like another member of that type than any member of any other type. The procedure for Elementary Linkage Analysis begins from a correlation matrix containing all the items which it is desired to cluster, and by a simple and rapid method assigns each item to a cluster, according to its primary linkage. A linkage is defined as the largest index of association which a variable has with any or all of the other variables. The lower limit of association used in constructing the clusters is determined by the data and does not require any arbitrary decision on the part of the operator of the method.

McQuitty (1957) discussed the underlying rationale of the method which, on a less sophisticated level, is analogous in some respects with factor analysis techniques. Elementary Linkage Analysis has however a different theoretical basis in that it is related to a concept of typal structures, not simple structures, of phenomena. This characteristic recommended the method for the purpose of this enquiry, in which a multiple rather than a unitary model of nursing function was expected. It was also recommended by its speed, economy and convenience.

The method was applied to matrices of correlation coefficients for each of the four main groups of items on the "Activity Schedule". It was not applied to the whole range of items in the check-list, because it seemed that an attempt to apply typal analysis across group boundaries would be inconsistent with the original postulate that the groups represented disparate levels or aspects of function.

9.5 Findings

It will be recalled that this series did not include contacts between nurses and patients at the injection clinic. In this series the location of contacts was as follows:

Table 9/1

Location of contacts in activity series

(percentage and number of contacts)

Location	%	(n)
Patient's home	83	(416)
Parent hospital[Ø]	9	(46)
Other	8	(38)
		(500)

Ø In ten of these cases the patient was transported from home to hospital or vice versa

Five main types of analysis were carried out:

(i) Frequency counts of all items were made

(ii) Linkage analysis of types of activity, observation, interpersonal procedure and topic was carried out.

(iii) Number of responses per group was related to other variables.

(iv) Items were related to features of the contact situation

(v) Items were related to characteristics of the patient.

The results of these analyses are dealt with seriatim below.[ø]

(i) Frequency Counts

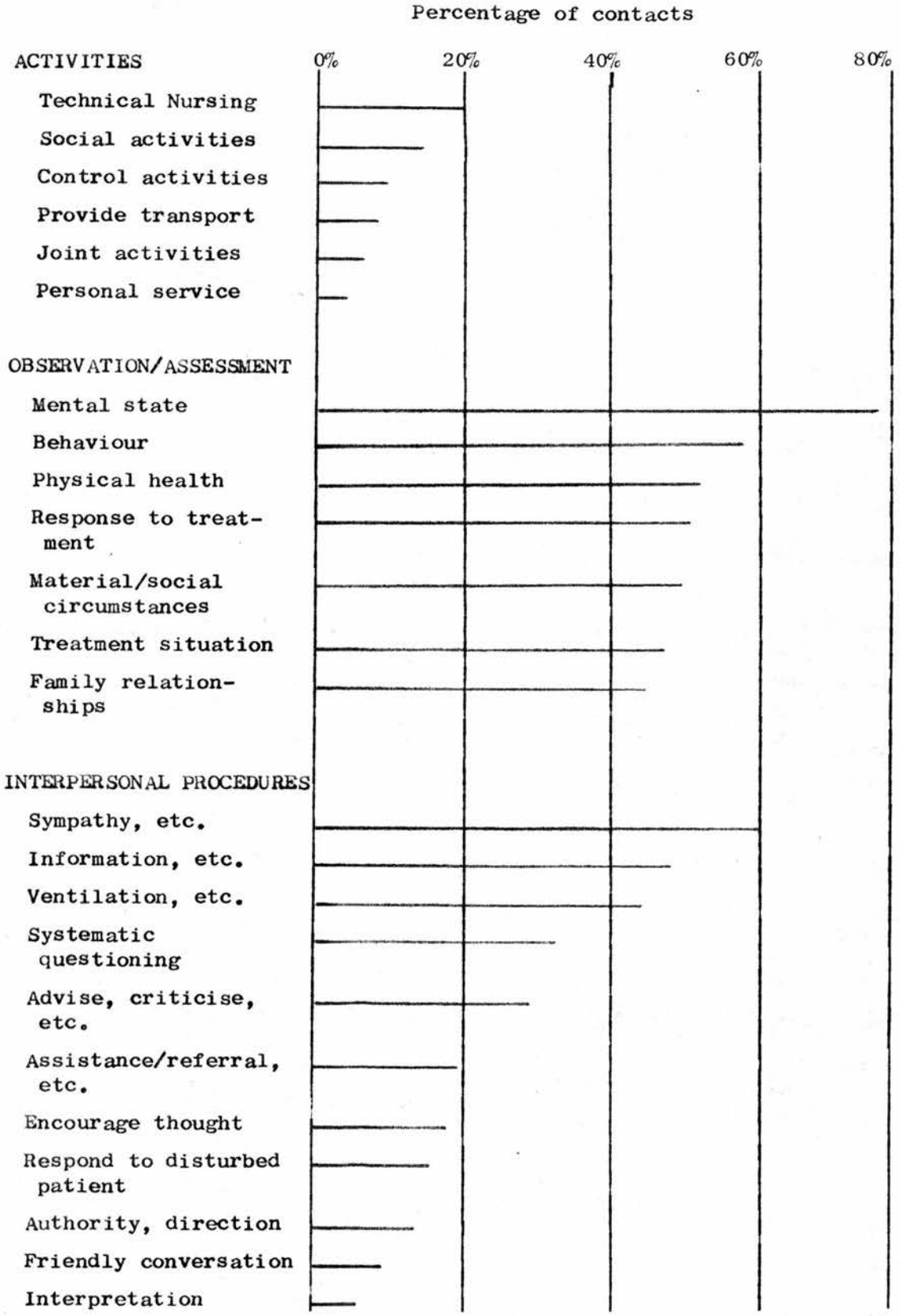
The number and percentage of events in this series of contacts at which each item on the check-list was recorded are given in Annex 9/2 (Tables A9/2.1 to A9/2.4). Percentages are also shown in Figure 9/0. and in Figures 9/1 to 9/4. The relative importance of the various groups of items, and individual items, as components of nursing activity as a whole in this setting may be inferred from their relative frequency, which is shown in the form of a graph in Figure 9/0. This makes clear the overall preponderance of observation items as modes of nursing activity, followed in second place by talking and listening procedures, from which much of the observed material was derived. Other types of motor activity are comparatively infrequent.

Tables A9/2.1 to A9/2.4 also show for each group how the number of items recorded per event was distributed. The median number of items in the "Activities" group was zero; medians for the other main groups were: four "Observations", three "Interpersonal procedures" and five "Topics".

The most frequently recorded item of all in any group was the observation of mental state - at almost 80% of contacts. Observation items were more frequently recorded than items in any of the other groups, and five out of the seven items were used at more than 50% of contacts. Only one of the Interpersonal procedures and Topics were recorded so frequently.

The Activities group of items was arranged in four categories each having several sub-categories (see Annex 4/3.1). The number of items recorded in many of the sub-categories was very small; for purposes of further analysis these were generally aggregated into the

ø All associations and correlations mentioned in this section, unless otherwise stated, reached significance at the 5% level of probability. Standard Chi-square methods were used to test associations and differences between variables. For correlations, the value of Phi at which a given level of significance was reached could be calculated for the whole series. With 500 observations, the 5% level is reached when Phi $\geq$ 0.100; the 1% level when Phi $\geq$ 0.122 (both two-tailed tests)



PROCESS AND CONTENT OF NURSE-CLIENT CONTACTS: RELATIVE FREQUENCY OF ITEMS

FIGURE 9/0 (Part 1)

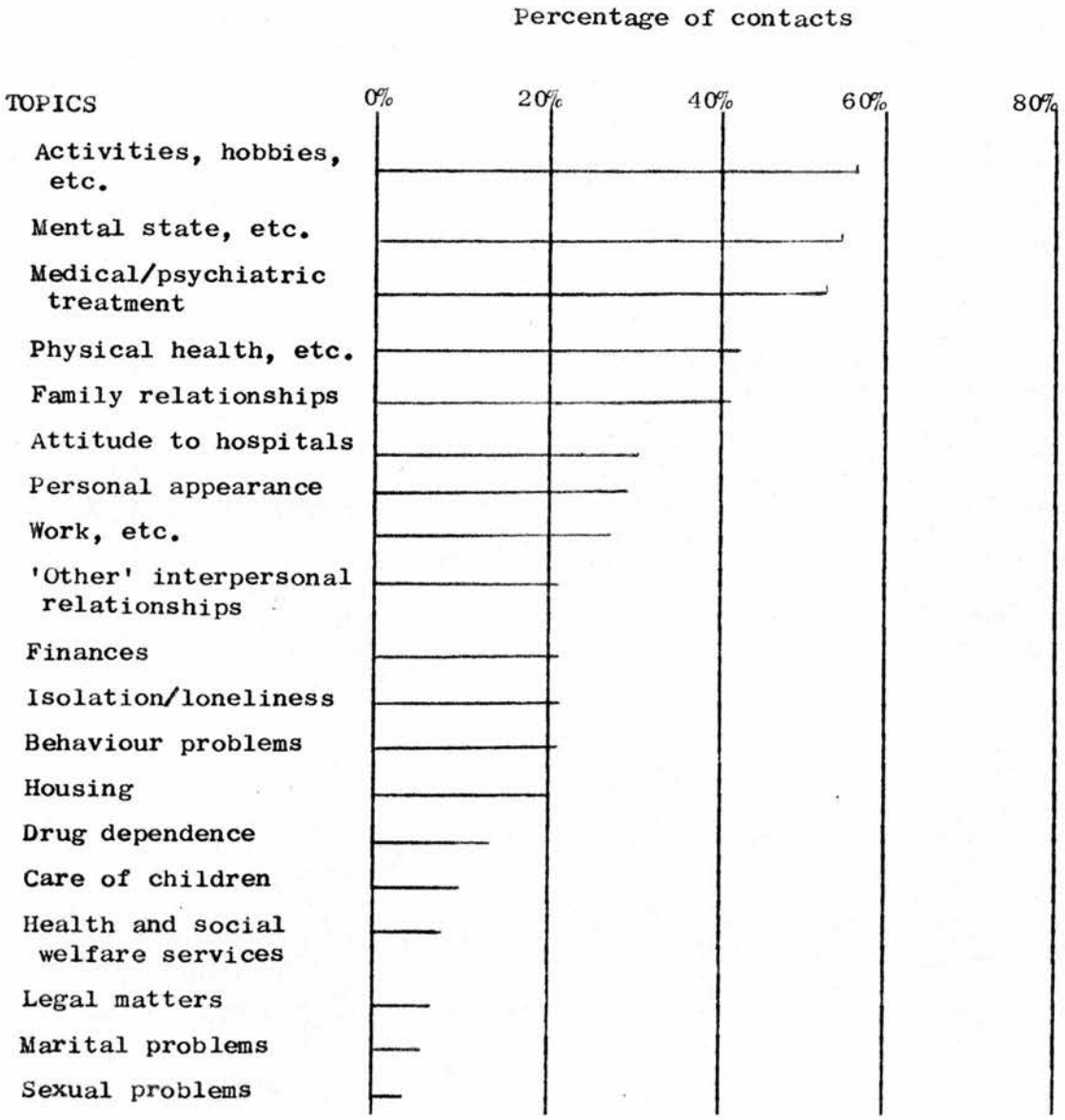


FIGURE 9/0 (Part 2)

larger categories. The two exceptions were "Providing transport" and "Social activities". These were originally sub-categories, respectively, of "Personal service" and "Joint activities", but each of them occurred so much more frequently than the other items in the same category that it would have given a false impression to aggregate them with the rest. They have therefore been treated as separate categories.

It became clear that the definition of the items specified under "Personal service" and "Joint activities" was unsatisfactory and that the two categories were not mutually exclusive.

Joint Activities was intended to show nurses' activity in the field of rehabilitation; these items were recorded at 6% of contacts. No entries were recorded in the sub-category "Recreational activities". The activities designated on the check list under the heading "Regulation and guidance of client's behaviour" are shown in the diagrams and tables as "Control" activities. Examples of "Joint Activities" described under "Other" are:

Accompanying a patient to visit prospective lodgings
Helping to pack a suitcase to take to hospital
Escorting a patient to see the body of a deceased relative
Reading a letter aloud for an elderly patient
Helping to repair a radio
Accepting a gift of clothing for the hospital
Taking a depressed old man for a drive.

These activities seemed to be not so much aimed at re-establishing social skills, as at providing emotional support.

The activities shown under the heading of "Personal Service" included those described in other studies as "Basic nursing care" - for instance, washing a patient or giving him food and drink. These items occurred very infrequently (at less than 2% of contacts).

In the category of "Control" activities, the most frequently occurring item was "Escort" duties. Many of these events were concerned with the removal to hospital of severely disturbed patients, and with escort and similar work with in-patients and day-patients. 15 out of the 35 "Escort" events ended with the patient in hospital as an in-patient - in 9 cases on a compulsory basis. "Escort" duties were most frequently recorded by male nurses. The majority of "Escort" contacts were initiated either by a psychiatrist

(13) or by a ward nurse (9). Escort events accounted for a third of the contacts initiated by ward nurses and a sixth of those initiated by psychiatrists. Such activities tended to be time-consuming, and often involved unsuccessful visits and searches which were not recorded in the series of contacts.

(ii) Correlation and Linkage Analysis of items in functional groups

Typal relationships between items within the four functional groups were demonstrated by means of McQuitty's method of Elementary Linkage Analysis (discussed above). The results are shown in Figures 9/1 to 9/4. The correlation coefficients on which the analysis was based are shown in Annex 9/2 (Tables A9/2.5 to A9/2.8).

The appropriate correlation coefficient in this case was the fourfold point coefficient of correlation (Phi). Because of the method of calculation, Phi does not take negative values, but the association which it represents may be negative - that is, one item may tend to occur in the absence of the other. Such associations have been indicated in the tables and diagrams as negative.

In the Activities group the aggregated categories were used for this analysis, the frequency of the individual sub-category items being below the level at which Phi correlations are valid.

Tables A9/2.9 and A9/2.10 show correlations between Topics and items in the Observation and Interpersonal procedures groups. The correlations demonstrate a substantial degree of correspondence between the topics discussed and some areas in which observation was recorded. Observation of mental state and of material and social circumstances were not however highly correlated with related topics.

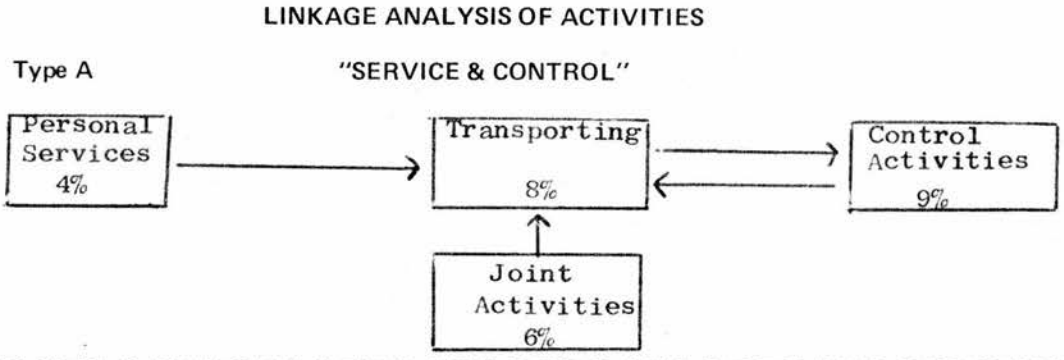
Two or three types of function emerged in each of the four groups on the check-list. These have been named (by the present writer) as follows:

Activities

Type A - Service and control activities
Type B - Expressive versus instrumental activities

Observation/Assessment areas

Type A - Personal/medical area
Type B - Family problems area



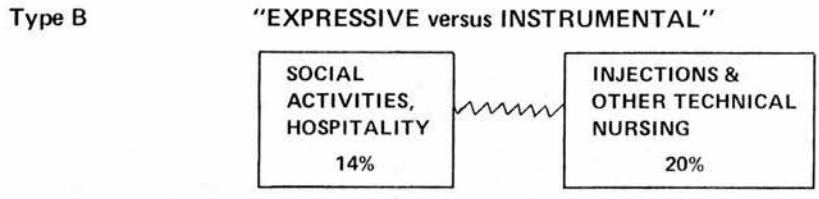
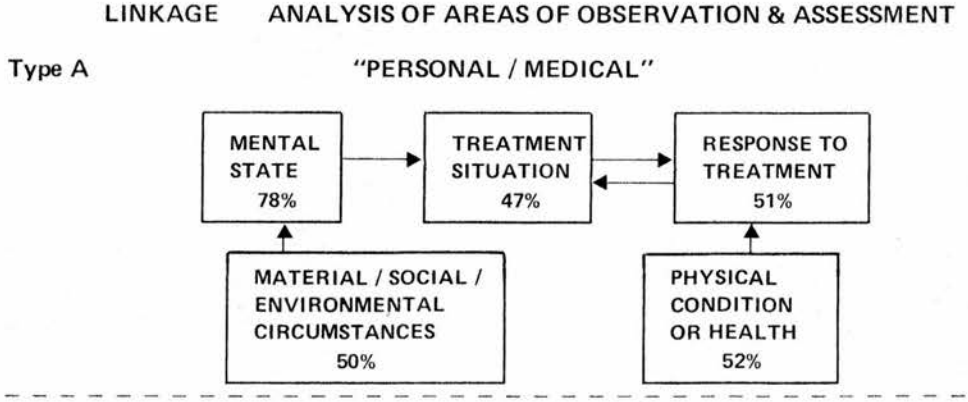


FIGURE 9/1. NURSES ACTIVITIES AT NURSE–PATIENT CONTACTS: CLUSTERS DERIVED FROM ELEMENTARY LINKAGE ANALYSIS.



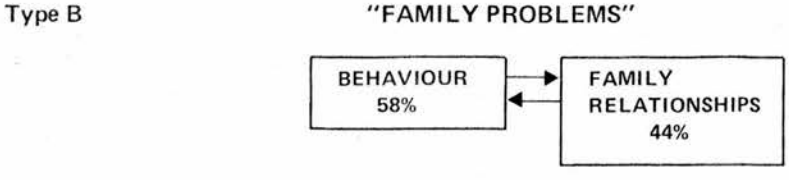


FIGURE 9/2. NURSES' OBSERVATION AT NURSE–PATIENT CONTACTS: CLUSTERS DERIVED FROM ELEMENTARY LINKAGE ANALYSIS.

⟷ denotes a positive reciprocal relationship between two items

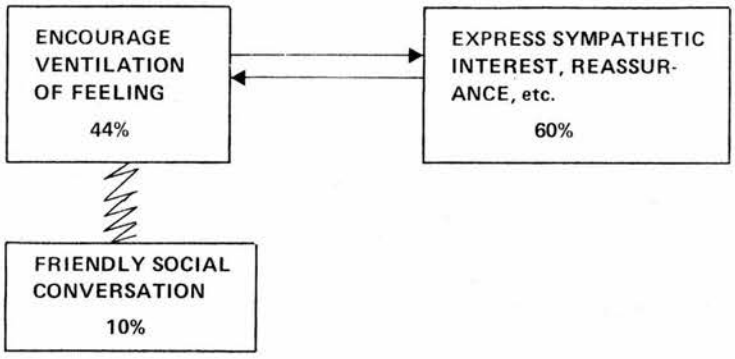
→ denotes that an item at the tail of the arrow has its highest correlation with the item at the head of the arrow

⇝ denotes a negative correlation between two items

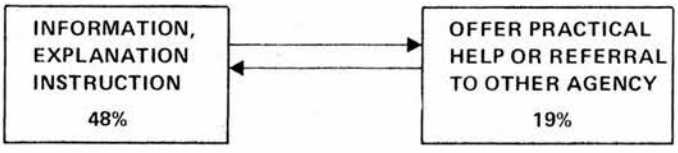
% against each item denote the percentage of events at which they were reported

LINKAGE ANALYSIS OF INTERPERSONAL PROCEDURES

Type A "EXPRESSIVE"



Type B "DIRECT ASSISTANCE"



Type C "CLARIFICATION & CONTROL"

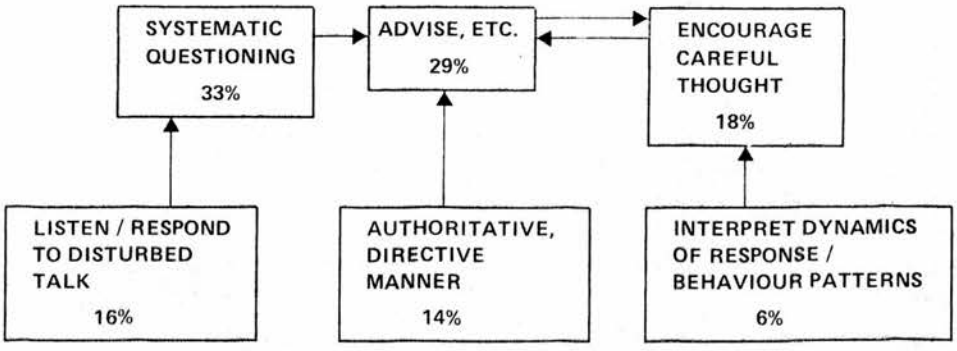


FIGURE 9/3. NURSES' INTERPERSONAL PROCEDURES AT NURSE–PATIENT CONTACTS: CLUSTERS DERIVED FROM ELEMENTARY LINKAGE ANALYSIS.

denotes a positive reciprocal relationship between two items

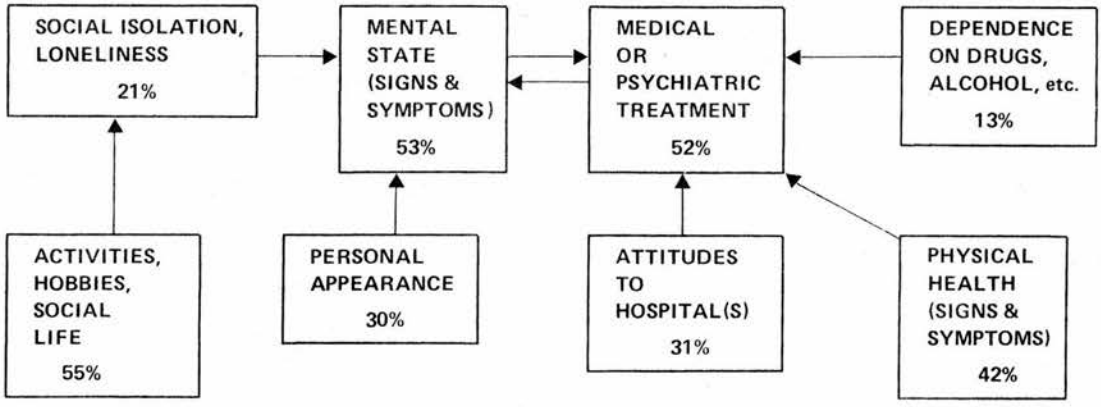
denotes that an item at the tail of the arrow has its highest correlation with the item at the head of the arrow

denotes a negative correlation between two items

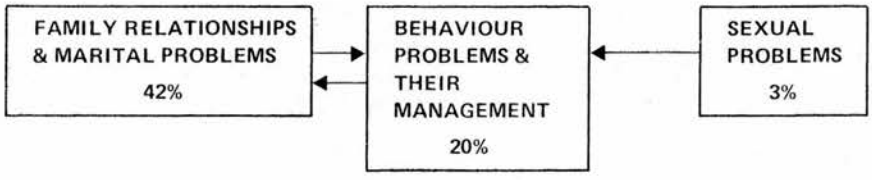
% against each item denote the percentage of events at which they were reported

LINKAGE ANALYSIS OF TOPICS

Type A "PERSONAL / MEDICAL"



Type B "FAMILY PROBLEMS"



Type C "SOCIAL NEEDS & RESOURCES"

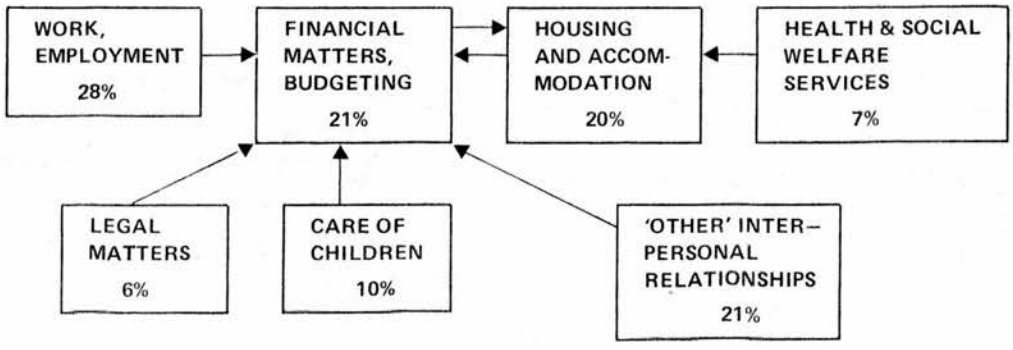


FIGURE 9/4. TOPICS DISCUSSED AT NURSE–PATIENT CONTACTS: CLUSTERS DERIVED FROM ELEMENTARY LINKAGE ANALYSIS

⟷ denotes a positive reciprocal relationship between two items

⟶ denotes that an item at the tail of the arrow has its highest correlation with the item at the head of the arrow

% against each item denote the percentage of events at which they were reported

Interpersonal procedures

Type A - Expressive procedures
Type B - Direct assistance procedures
Type C - Clarification and control procedures

Topics

Type A - Personal/medical topics
Type B - Family problems topics
Type C - Social needs and resources topics

The components of each type are shown in the diagrams. The percentage of contacts at which each item was recorded is also shown.

(iii) Number of responses recorded in each group of items

The number of positive responses recorded was assumed to be in some sense a measure of the nurse's level of concern or activity. The total number of responses per contact in each of the main groups of items was calculated, and these totals were related to:-

(a) the initiator of the contact

(b) the clients present at the contact - viz: the identified patient only, the patient and members of his family, or a family member or members only

(c) a broad diagnostic classification - viz. schizophrenic type of illness or other category

(d) the number of Topics responses was analysed, in addition, in relation to the sex, age group, and social class of the identified patient.

Detailed results from these analyses are given in Annex 9/3. The principal findings were as follows:

(a) There was a trend (reaching significance at the 5% level in the case of Interpersonal procedures only) for a higher number of Observations, Procedures and Topics to be recorded at contacts initiated by psychiatrists than at those initiated by community psychiatric nurses. No difference was evident in the case of Activities.

At contacts initiated by ward nurses multiple (viz: 2 or more) Activity items were particularly likely to be recorded, while fewer Observations and Topics were likely. No difference in the number of Interpersonal Procedures was observed in relation to this variable.

In this series, 86% of the contacts initiated by ward nursing staff were concerned with in-patients or day-patients of the parent hospital.

These results suggest that contacts initiated by ward nursing staff were often principally concerned with the execution of a specific task or tasks which did not involve assessment of the patient or his circumstances. Other data showed that the activities involved were mainly connected with tracing non-attenders, delivering medication, and helping to make arrangements for patients' accommodation after discharge from hospital.

(b) Areas of observation or assessment, as indicated by the number of Observation items recorded, were significantly enlarged where patients were seen together with family members. This difference did not appear to be due to greater communicativeness on the part of family members.

(c) More numerous Activities items were recorded in cases involving schizophrenic patients than patients in other categories. This difference can probably be attributed to Technical nursing and Control activities, both of which were more likely to be recorded at contacts with schizophrenic patients.

Fewer Interpersonal procedure items and Topics were recorded when schizophrenic patients were involved. This was predictable when it is recalled that disordered or impaired modes of communication may be criteria for a diagnosis of schizophrenia.

(d) Significantly higher numbers of Topics were recorded by female nurses, and in cases where female patients were involved. Where the patient was elderly, high numbers of Topics were less likely to be recorded than with younger patients. No difference was associated with the patient's social class.

(iv) Examination of responses in relation to features of the contact situation

Analyses were carried out to show how far the use of individual items on the check list was associated with particular features of the contact situation. The variables examined were:

1. The clients present at the contact - that is to say, the patient alone, member(s) of the patient's family alone, or the patient together with member(s) of his family.

2. The status of the patient at the time of the contact in relation to the parent hospital - viz: out-patient, community patient, in-patient or day-patient.

3. The initiator of the contact (in relation to Observations, Interpersonal procedures and Topics only)

4. Whether or not the contact was the initial contact between the community psychiatric nursing service and the case. (Observations, Interpersonal procedures and Topics only).

5. Whether or not the nurse detected (and recorded) a noticeable change in the patient's condition or behaviour (Observations and Interpersonal procedures only).

6. Whether or not the nurse detected and recorded a source of extra stress affecting the patient (Observations and Interpersonal procedures only).

7. Whether the contact involved the nurse and one client (a dyadic interaction) or a larger group of persons (Interpersonal Procedures only)

A large number of tabulations of the data were produced which it is impracticable to reproduce in extenso. By the laws of probability, among such a mass of data a certain number of random associations were likely to occur, and it seems uncertain to what extent the apparent differences ought to be taken at face value. However, since some of the findings illuminate other aspects of the data, and some are interesting in their own right and suggest directions which further investigations might take, a summary of the significant findings has been included (Annex 9/4) in the report.

There is a clear tendency for the check-list items to group themselves, in association with contact variables, according to the types demonstrated in the typal analysis. This may be illustrated by reference to items associated with initiation of the contact by a psychiatrist - viz: Observations falling into Type B ("Family problems")and Topics of Types B and C ("Family problems" and "Social needs and resources").

The status of out-patient was associated with comprehensive observation of mental state, treatment factors and environmental factors. The status of community patient, on the other hand, appeared to be associated with a less formal and clinical type of care conducted on a 'friendly' footing. Attention to physical health factors was also associated with community patient status.

Initiation of contacts by a psychiatrist was associated with procedures of practical help, analysis and interpretation of the patient's patterns of behaviour, and observation and discussion of family and environmental factors. Initiation by a community psychiatric nurse was associated with "Friendly social conversation" and somewhat general topics. The implications of these findings are discussed below.

(v) Examination of responses in relation to characteristics of the identified patient

Analyses were carried out to show the extent to which the use of individual items from the check-list was associated with particular characteristics of identified patients. The patient-variables examined were:

1. Sex
2. Age group
3. Social class grouping (Classes I to III and classes IV and V)
4. Diagnostic group (Schizophrenic or other category)
5. Duration of the patient's previous psychiatric history
6. Length of time since the patient's latest discharge from psychiatric hospital.

The first three variables were differently distributed in the two diagnostic groups, and sex and age group distributions were also associated. Further analyses were carried out where necessary to take account of these possibly misleading factors.

Like the data described on the last page, this material cannot be presented in detail in this report. The same reservations about the significance of the findings also apply here.

The findings are summarized in Annex 9/5.

9.6 Discussion

(i) The method

One of the objects of the enquiry described in this section was to find a systematic method of describing different levels or aspects of psychiatric nursing activity. The method concentrated entirely on those

aspects of the nurse's work which are undertaken in association with patients and families and ignored all the organizational, managerial and communication functions which support and complement the nurse's direct patient-care functions.

The instrument was designed with particular reference to the exigencies of the so-called 'community' working environment; but it could probably be adapted for use in other situations and for other purposes.

Paradoxically, the method was relatively successful in dealing with aspects of the nurse's work which, because of their abstract character, were expected to present greater difficulties of definition and identification. Conversely, it proved less successful in handling the more concrete components of the nurses' work - the very things which, because of their relative observability, were expected to be more easily described and categorized. It must be supposed that the initial analysis of these activities was inappropriate, too superficial, or inadequately defined and explained. There were certainly problems in finding unifying features in apparently very diverse activities. The attempt to distinguish some activities in terms of their purpose - rehabilitative or compensatory - did not prove a successful basis for analysis.

The purpose for which the method was utilised in this study was to help define the nurses' own conception of their functions. It remains uncertain whether the results represent what the participating nurses thought they had actually done, what they thought they ought to have done, or what they thought the researcher expected them to do. It is likely that all three elements contributed to the data in proportions which cannot be ascertained. That is to say,the content validity of the method has not been established. In this instance, where the method was used with a very small and highly cohesive group of nurses, all trained and continuously employed in the same institution, it was assumed that their semantic and ideological interpretations of the instrument would not be seriously incongruent. The same assumption could not be made without further enquiry for nurses in different settings, and if the method were to be used for comparative purposes, it would be necessary to validate it. The question of validity would assume even greater importance in using the instrument to compare

different occupational groups, or in evaluative studies using independent measures of the effectiveness or acceptability of different methods of care.

The instrument does however have apparent or 'face' validity, which would be supported if similar results were produced when it was used by psychiatric nurses from similar backgrounds and situations.

It is important and indeed urgent to develop valid and systematic methods of describing functional aspects of psychiatric nursing, in whatever setting it is practised. Without such methods it is impossible to establish the value or effectiveness of particular aspects of practice except on an intuitive or a priori basis. Valid analytic methods of describing nursing practice are needed not only for research and evaluation, but also for use in teaching, in supervising standards of nursing care, and for individual practitioners to use as a yardstick for assessing their own practice.

(ii) The implementation of the method

The proposition of different levels of activity appeared to present no difficulties to the nurses participating in the study; but the initial presentation of the section of the check-list on Interpersonal procedures provoked some misgivings and an interesting discussion. A feeling was expressed that the analysis of nurse-patient interaction in terms of techniques or procedures implied an element of insincerity and conscious manipulation on the nurse's part, and that this was objectionable. The essence of effective psychiatric nursing was said to lie in the spontaneity and directness of the nurse's rapport and response to the patient. It was considered wrong to suggest that an intellectual or cognitive process could be interposed between reaction and response. The issue was discussed without apparently being resolved; but the difficulty seemed to recede as the use of the check-list became familiar.

This enquiry was not extended to include nurse-patient interaction at the nurses' injection clinic; in retrospect this omission was regretted. A comparison of nurses' activities in the two settings would have shown the practical consequences of the different aims and orientation associated with the two situations. It seemed likely

that clinical types of activity, assessment and content would be more prominent at the clinic than in domiciliary practice. This assumption was supported by other data (see section 12); but in the absence of descriptive information on a comparative basis, the assumption cannot be tested.

(iii) Results 1: frequency as an indication of perceived priority

The simplest form of analysis - the frequency counts for each item - tell us much about the priority attached to clinical and psychosocial factors in the practice of this service. A limited "technical nursing" function was identified, predominantly associated with the administration of drugs and with schizophrenic patients. The bulk of this type of work consisted of giving injections and was concentrated at the injection clinic. It was clear that technical nursing procedures occupied a relatively insignificant place in the nurses' domiciliary work, and that basic nursing functions were even less frequent. This finding does not conform to the accepted stereotype of the nurse as a worker who gives active and practical care. On the other hand, the nurse's function as a trained observer receives pride of place, clinical observation and assessment assuming outstanding importance. The content of nurse/patient interaction also showed a preponderance of topics concerned directly or indirectly with the raw material of clinical assessment. Discussion of personal relationships and of related subjects such as loneliness took second place to that of symptoms, treatment and social performance. Although clinical procedures as such may have been comparatively infrequent, a large proportion of the data obtained at nurse-patient interviews was apparently interpreted and reviewed from a clinical standpoint.

The lack of active rehabilitative work with patients, by means of activities in which the nurse and the patient participate together, was noteworthy. There are several possible reasons why this type of nursing care was not transferred from the hospital to the community setting: the time-consuming nature of such work, to which a regular commitment is often required; the lack of a tradition of rehabilitative work in domiciliary settings; difficulties over operating in others' territory; and the presumption that the discharged

patient should be capable of coping with daily life outside hospital.

The category of activities designated as "Control activities" (or "Regulation and guidance) covered occasions when the community psychiatric nurses were asked to undertake the removal to hospital, under compulsory powers, of severely dist bed patients. The responsibility for such work formerly rested largely with local government staff - 'duly authorised officers', later superseded by Mental Health Officers. The devolution of this work upon the hospital service came about in 1968 upon the dissolution of a separate mental health service. It seems clear that in such cases the nurses undertook a quasi-police function which was custodial rather than therapeutic. Nevertheless they derived considerable satisfaction from the skill which they acquired in carrying out these assignments with the least possible formality or fuss and with the utmost consideration for the patient and his family. Their importance for the nurses as a component of their role was probably greater at the time of the study than might appear from the relatively minor proportion of contacts concerned.

(iv) Results 2: the application of interpersonal skills

Nurses are commonly expected to provide 'support' for patients and families, and this expectation was shared by the participating nurses (see section 12 below) and their colleagues (see section 10). 'Support' is a word as useful as it is vague. What exactly does the metaphor signify in this context? What activities does it denote? What meaning do they have for the recipients? Does the character of 'support' vary in different situations? For what purpose is it given, amd how can we judge whether it is effective? None of the nursing texts consulted by the writer defined 'support' in operational terms.

The writer suggests that the two Interpersonal procedures*

*The use of these 'supportive' procedures was associated with the sex of the recording nurse. As they were significantly more likely to be recorded by a female then a male nurse, it must be concluded that in this case the male nurses were less supportive to their patients or more selective in the application of the procedure. In Western society, the primary roles of women are said to be 'expressive' rather than task-oriented. 'Expressive' roles are said to be concerned primarily with maintaining equilibrium within social systems and with keeping tension and friction within manageable limits. Johnson and Martin (1958), writing of the American situation in medicine and nursing, suggested that feminine, expressive roles were undertaken by nurses, while masculine, task-oriented roles belonged to doctors. The findings of this study suggest that the influence of the nursing role on the behaviour of the male nurses had not entirely displaced the customary differences between sex-related social roles.

defined by the linkage analysis as Type A (Expressive) procedures (Figure 9/3) may be regarded as denoting 'support' as practised by this group of nurses. (The two procedures in question are "Allow or encourage ventilation etc." and "Express sympathetic interest etc.") On this assumption , 'to support' means to help people obtain relief through the expression of painful or negative feelings, and to reduce the guilt and anxiety which this evokes in the subject by the expression of sympathy, interest and reassurance.

This definition does not include a function which no doubt provides considerable support for some types of patient, but which only requires normal social skills - that is, the Procedures item "Friendly social conversation". This item had non-significant or negative correlations with all other items except one - the Activities item "Social activities/hospitality", with which it was positively correlated. "Friendly conversation" was more likely to be recorded at visits initiated by a community psychiatric nurse, at visits to community patients, and at contacts with patients aged 65 or over. These findings indicate a type of social visiting undertaken by the nurse on her own initiative, the primary purpose of which was to provide friendly social contacts for elderly and perhaps lonely people. Although such visiting is undoubtedly valuable as a preventive measure, it is likely that in some cases it could be equally well done by a lay person, if suitable voluntary workers were available. These findings may reflect a feature of the service which will be commented on (section 13.7) - an apparent reluctance to terminate services to patients.

It was expected that the supportive methods would be closely associated with directive procedures, particularly "Advise, criticise etc.", because the success of these depends, in theory, on a relationship of trust and acceptance between patient and therapist, which should be fostered by the expression of sympathy and encouragement. But there were no significant correlations between the two 'supportive' procedures and those which can be regarded as directive (i.e. "Advise etc.", "Systematic questioning", and "Use authoritative/directive manner".) Either no need was seen for supportive measures to back up attempts to exert a direct influence, or else the directive procedures were used in situations in which supportive measures were not feasible.

A cognitive, or reflective, approach to problems was defined in two categories of Interpersonal procedures. These were: "Encourage the

client to think carefully about the nature or effects of his current situation or behaviour"; and "Interpret to the client the origin or dynamics of his patterns of response and behaviour".

On the basis of nursing texts on 'one-to-one' nurse-patient relationships (using American sources which follow Rogers' precepts on the essentials of psychotherapeutic intervention), it was expected that cognitive procedures would generally be components in a continuing process of nursing treatment, but that they would be accompanied by liberal applications of supportive procedures, and that they were likely to be used very sparingly, if at all, in the initial or introductory phases of an individual patient's treatment (Travelbee 1969, pp 155-159 ; Kalkman and Davis 1974, pp 565-569).* It was also expected, on general principles, that these procedures would be used more freely with non-schizophrenic than with schizophrenic patients, and for similar reasons that they would be more likely to be used with family members than with psychiatric patients themselves.

These expectations were only partially realized. Cognitive procedures were found to be more likely to be used with people in social classes I, II and III, and less likely with people aged over 65, and people diagnosed as schizophrenic. (These associations did not all reach significance at the 5% level). This was as expected, since psychotherapeutic treatment is considered suitable only for people who are relatively well-educated, have some verbal ability and competence at conceptual thinking, and have sufficient 'ego-strength' and adaptability to be able and willing to change. However, no difference was associated with the presence or absence of family members. The linkage analysis showed that the two cognitive procedures belonged to the same 'Type' as various directive and other procedures (see Figure 9/3).

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* Hollis (1972 pp 174-5) describes a study of the application of her typology to the analysis of successive interviews in 15 cases of marital counselling, comparing the use of the various procedures as the course of treatment progresses. She shows that reflective discussion of current issues and of dynamic and developmental factors was always comparatively rare. Sustaining and ventilating communication were at their highest level in initial interviews but ventilation remained consistently the procedure used most frequently.

These were significantly associated with initial contacts and with events at which the nurse noted a deterioration in the patient's behaviour. It seems clear that the cognitive or reflective approach was not used as a means for developing increasing understanding, insight and control of behaviour; but that it was rather being used as an adjunctive technique in crisis intervention along with investigative and directive measures. The appropriateness of 'reality confrontation' in such situations is not questioned, but the use of procedures of interpretation may be open to criticism. In view of the nurses' opportunities for long-term work both with patients and relatives, it was expected by the writer that these techniques would be used, with due caution and accompanied by supportive methods, in a more planned and progressive way with a view to ameliorating some of the prevailing family relationship problems.

It may be inferred, then, that the nurses were prepared in situations of crisis to make use of methods used or observed in group psychotherapy sessions, but that they lacked skill, experience and supervision that would equip them to use these methods in other appropriate situations and to the best effect.

(v) Results 3: some unexpected associations between variables

Some of the associations between check-list items and contact-variables (Annex 9/4) seemed paradoxical or at least unexpected. Three of these puzzles might merit closer investigation.

The first is the finding that higher numbers of items were recorded when the contact was initiated by a psychiatrist. This might be because the situations signalled by psychiatrists tended to be problematical, so that it was the demands of the situation rather than those of the initiator which evoked an active response. One can speculate that news of crisis situations in 'the community' were likely to be transmitted to the community psychiatric nurse via the general practitioner and a psychiatrist. However, as information was not collected about the reason for contact, the situation found and the outcome, it is impossible to do more than speculate on the relationship between initiation and the kind of situation dealt with. Another possible explanation for this finding could be that the interest of a psychiatrist in her work stimulated the nurse to more

comprehensive activity. If this conjecture were correct, it would have implications for referral policies, for the organization of services, and for arrangements for supervision and consultation for community psychiatric nursing staff. Such conjectures could be multiplied, but it is useless to speculate in the absence of a clearer understanding of how community psychiatric nursing visits come to take place.

A second unexpected finding was that when the nurse recorded a change for better or worse in the patient's condition or behaviour, the only areas in which observations became more likely were "Behaviour" and "Response to treatment". Assessment of mental state remained at its general high level. This suggests that precipitants for such changes may have been looked for primarily in medication and treatment factors, and not in the social environment or in family relationships. That is to say, faced with change, the nurse tended to employ a medical frame of reference.

A third paradoxical result was that, when the nurse recorded some form of emotional or environmental stress affecting the patient, several areas of observation (mental state, response to treatment, treatment situation and family relationships) were significantly less likely to be recorded than on occasions when no such stress was recorded. This was surprising; many people would regard family relationships as the most likely source of emotional stress. Apparently, however, the identification of stress, which in effect was a challenge to the nurse's ability to help the patient, tended to be met by a form of withdrawal from the situation.

It is difficult to know how much weight to attach to these somewhat tenuous indications. As noted above, some of the statistical associations may be due to random factors, although all cannot be dismissed on this score. Taken together, these findings suggest that a more detailed study of the antecedents of nurse-patient contacts, and of the nurse's response in functional terms to the situation which she finds, would show how far it might be possible to promote more effective functioning in stress situations by additional training, supervision or support.

9.7 Summary

A method of analysing psychiatric nursing practice in situations of contact with the patient is described. A self-administered record schedule was used, comprising 55 descriptive items, arranged in four groups corresponding to four aspects or levels of function - viz: Activities, Observation or Assessment, Interpersonal Procedures and Topics. The results were analysed using conventional frequency counts, and linkage analysis of the items in the four groups was carried out. An attempt was made to relate functional items to features of the contact situation and characteristics of the client. The findings showed the relative importance of the various items and groups of items in the work of the service. Evidence as to the combinations in which items occurred is discussed and attention is drawn to some unexpected associations between circumstances and practice.

SECTION 10 PERCEPTIONS AND EXPECTATIONS OF THE USERS OF THE SERVICE

Psychiatric nurses have not hitherto engaged in independent case-finding; they can influence the composition of their clientele only to a minor extent by accepting or refusing cases. Selection of cases comes about largely through the process of referral; and the people who make referrals are in a position to affect the nurses' activities in two ways - by the type of cases they refer, and by what they ask the nurses to do.

Information was available about the people who referred new cases to the service (see Section 7). It was decided to make a supplementary enquiry to indicate the extent of agreement or disagreement among users of the service about its functions and relationships with other parts of the hospital and community services.

In order to identify sources, all the referrals of which the writer became aware during the study period were reviewed; those included cases from the study sample and others from the non-sample group. Referrals to the injection clinic (which are regarded as referrals primarily to the psychiatrists in attendance) and for various ad hoc tasks giving the nurse no continuing role in the patient's care, were discarded. The following referral sources were identified:-

Parent hospital staff:	
Psychiatrists	17
Social worker	1
Charge nurses	2
Psychiatrist at another hospital ..	1
Hostel staff	2
	23

All of the referrals by staff of the parent hospital came from seven clinical teams to which a community psychiatric nurse was attached. The number of referrals from individuals varied between one and five and from teams, between one and thirteen. All those who made major

demands on the community psychiatric nursing service during the study period were included in the enquiry, but no individual was interviewed more than once, irrespective of the number of cases he referred.

The method of enquiry used was a semi-structured interview, based on a list of topics which were covered as far as possible at each interview. The method of constructing the list (see Annex 4/6) and of arranging and conducting the interviews is briefly described in Section 4.

Two psychiatrists - one who left the REH shortly after the referral and one employed at another hospital - were not interviewed because of difficulties of time and travelling. All the 21 people approached agreed to be interviewed and their opinions are briefly reviewed in this section. The views discussed are virtually those of a homogeneous professional group, since those of the social worker and the two nurses did not differ substantially from the psychiatrists.

Most of the interviews took place between two and three months after a referral was made. The writer invited each respondent to discuss a particular case or cases referred during the study, but as a number of others were mentioned, the case-material discussed was haphazard.

The principal areas discussed were:-

1. Reasons for using this service.
2. Functions of the service.
3. The respondents' opinions of the service

10.1 Reasons for selecting the services of the community psychiatric nurse

Why were cases referred to this rather than to an alternative service?

The process of referral was described by one respondent as "matching the service to the patient's needs". Although in a few of the cases discussed the nurse seemed to have been called in to provide a minimal service for patients who "did not need to be seen by a psychiatrist", far more often the appropriateness of the individual nurse's skills, approach or personality were given as a primary reason for the referral. Nurses were considered to have special skills, developed through their experience in hospital, in

communicating with and making 'relationships' with disturbed people, and in such cases, particularly if some form of emergency action was likely to be required, community psychiatric nurses were seen as superior to any other available community service. Other situations for which they were considered particularly well qualified were: (i) where assessment or observation of a patient's mental state and clinical needs was required; (ii) where the patient had concomitant mental and physical disabilities or a mental disorder with an organic basis; (iii) where maintenance of a drug regime and observation of side-effects were important (particularly emphasised by the two charge nurses).

Although a majority of respondents said that one of the community nurses' main tasks was to care for people suffering chronic relapsing psychoses, selection of cases for the service was not in general based on specific diagnostic criteria. Where diagnosis was cited, views varied widely: several psychiatrists thought that most nurses were better at dealing with psychotic than neurotic problems, but another said that his own team "mostly refer neurotic or hysterical people or personality disorders". A third, again, thought that the community psychiatric nurse ought not in present circumstances to be asked to deal with personality disorders, but he could envisage their doing so satisfactorily if they became more closely integrated with the clinical teams. Some psychiatrists felt that where medico-legal responsibilities were involved - for instance, with potentially violent or suicidal patients - they must assess and follow through the case themselves; but, for others, the community psychiatric nurse made it possible on occasion to manage such cases satisfactorily outside the hospital.

Reasons for <u>not</u> referring cases included the need for specific 'social work' skills. Social work seemed to denote, for respondents, on the one hand dealing with complex legal, financial or administrative problems, and on the other hand dealing with marital problems or cases requiring a dynamic intervention in social relationships. No respondent mentioned both of these aspects of social work. Where a dynamic approach was considered undesirable, a nurse might be preferred - "somebody mature, experienced, relatively long-term, and not given to stirring things up".

Patients were apparently often chosen for referral on other social or personal grounds - the elderly, the housebound, the lonely and isolated, people without family and patients already known to the nurse. Some patients who were thought likely to become unduly dependent on a connection with the hospital were referred by psychiatrists in preference to following them up as out-patients.

The matching of nurses' skills with the characteristics of the patient was in fact only one of a number of factors mentioned as affecting referrals to this service. Mobility is an example - enabling contact to be maintained with patients who otherwise could not or would not keep in touch with the hospital. Contact with community resources was a second factor; for example, members of the service had acquired a wide knowledge of hostels and lodgings in the City of Edinburgh, and they were regarded as specialists, by hospital staff and by an outside respondent, at placing people in suitable accommodation. Other features of the service which were frequently mentioned with appreciation were ready accessibility, ease and informality with which referrals and requests could be made, promptness of response, and adequate time to deal with them. In these respects it was favourably compared with alternatives, both inside and outside the hospital, to which cases might otherwise have been referred. One of the community respondents valued the service as a means of direct access to specialized advice and where necessary to the other resources of the hospital.

A major factor appeared to be the extent of personal contact and integration of the community psychiatric nurses with the clinical teams. Several respondents stressed that the use they made of a nurse's services depended whether they could appraise how she was likely to handle a case. Community-based services with which hospital doctors had no personal contact were thus much less likely to be used, partly at least because their members' skills were an unknown quantity. The community psychiatric nurse was seen as providing "an extension of one's own service" and such a choice would not be made without personal knowledge. The same considerations applied to those members of the service who were not personally known to respondents. It was stated that, were it not for their team attachments, the nurses would only be called on for tasks like retrieving absconded patients. "It is the fact that the Community

Nurses are there that keeps them in mind".

Attitudes and orientation congruent with those of the psychiatric teams were attributed to the community psychiatric nurses. As members of the hospital staff, they were preferred to community workers who might lack a "psychiatric orientation" and who, if they did not "agree with our policy", were less open to influence or (as one consultant expressed it) "persuasion".

Respondents were asked what they would probably have done, in the specific cases discussed, if referral to the community psychiatric nursing service had not been possible. In a majority of cases, they named alternatives based within the hospital. Details of the alternatives given are as follows (the total exceeds 21, since in several cases more than one alternative was mentioned).

Hospital services	16	(psychiatrist 5, PSW 8, ward nurse 2, admit patient 1)
Community services	11	(GP 4, Health Visitor 4, Social Work Department personnel 3)
Don't know or do nothing	3	

Finally, a factor which influenced referrals was the type of service which the community nurses were believed to give. Compared (as they inevitably were) with social workers both inside and outside the hospital structure, the community psychiatric nurses were considered to give a more comprehensive and more lasting service. "Nursing ... is .... a situation in which somebody is prepared to deal with the patient, not merely to go and assess and say what the patient's requirements are ..... The nurse will ..... look after the patient as often as necessary ... and bring in the appropriate people for any specialized requirement". One respondent saw a difference in the focus of interest - a nurse would be more concerned with an individual patient whereas a social worker would support the whole family. There was also believed to be a difference in the emotional content of the nurse's care: " .... a warm feeling that they are people of comfort to the patient".

About half of the respondents said they had experienced problems in deciding to which service to refer cases, and that this had arisen particularly between nursing and social work. The others said they

had had no difficulty in deciding whether, in a given case, mental disturbance or social need was the prime factor. However, during the study period social work assistance seemed to have been rather unevenly distributed within the hospital, so that frequently the problem of decision had not arisen either because no social worker was available or because the nurse was far more readily accessible. In some of these cases the interviewer gained the impression that, had a psychiatric social worker been available, she would normally have been selected, more from custom than from a rational appraisal of appropriate skills. It was generally felt, however, that "generic" social workers were not competent in recognizing or dealing with problems of mental illness.

10.2 Functions of the service

Respondents were asked to specify (without prompting from the interviewer) what they thought were the community psychiatric nursing service's most important functions. All respondents felt that the service had multiple functions, no single one of which was "most important". Several qualified their responses by saying that they could not cover all aspects of the service's work from their own experience. The replies can be summarised under the following headings:

(1) Following-up discharged patients - (19 respondents) (including the administration and supervision of drugs and the conduct of a Modecate clinic)

(2) Giving support, advice and guidance to patients, families and others (13)

(3) Making assessments and seeking information for the benefit of the hospital or clinical team (11)

(4) Escorting disturbed people to hospital (7)

(5) Placing and supervising people in sheltered accommodation or supervised lodgings (6)

(6) Providing links with other community services (14)

(7) Dealing with crisis situations (3)

Discussion of specific cases filled out these outlines. The community psychiatric nurses' mode of operation was generally described in terms of supportive psychotherapy, guidance, advice and encouragement for patients and, where appropriate, for family members. Several psychiatrists and the social worker stressed that community nurses were not qualified to undertake cases where dynamic psychotherapy or a casework type of intervention was required. However, one psychiatrist said he preferred to work with a nurse in psychotherapeutic interventions; his experience had been that nurses were better able, certainly than 'generic' social workers, to handle such situations. The general view was that the nurses' expertise was in maintaining precarious social situations in some sort of equilibrium, rather than in producing dynamic change and development.

In a majority of cases some reference was made to the establishment of a 'relationship' from which the patient could derive therapeutic benefit or be helped to solve his problems of living.

One aspect of 'follow-up' was the supervision or administration of drugs. Most respondents considered the conduct of an injection clinic for out-patients as part of this function, but one psychiatrist actively objected to this well-established task which, in his view, was totally inappropriate since the clinic"just brings patients out of the community back to the hospital .... the opposite of what community nursing is about". Several psychiatrists challenged the idea (which they believed to be widespread) that, through the clinic, the community psychiatric nurses were concerned almost entirely with a clientele of chronic schizophrenic patients. One of them felt that there had in fact been an undue concentration on this group with a consequent neglect of other large categories of patients who could benefit greatly from psychiatric nursing care in the community.

Observation and assessment was an integral part of the nurses' expected functions in nearly all of the cases discussed. The process described as 'follow-up' generally included long-term observation of the patient for warning signs of mental or social deterioration, in order to prevent relapse or to avert crises. In a short-term context, nurses were asked to make specific enquiries about, for instance, home conditions or the circumstances of a patient's

admission as a basis for decisions about clinical management and social care. Nurses also carried out assessments of patients' condition and need for treatment, combined with intervention where necessary in crisis situations.

The areas of observation mentioned by respondents included patients' clinical status and mood, physical health, behaviour and level of performance, the effect of their condition on their families, and home circumstances in both environmental and interpersonal terms. Nurses were expected to recognize problems in family functioning, even by those who felt they were not qualified to intervene. 'Background reports' were described by three respondents as "the social worker's job" but one added that, as social workers tended to see people more in hospital, he would normally refer such cases to the community psychiatric nurse.

Many of the activities discussed by respondents were interchangeable between nurse and psychiatrist - for instance, clinical assessment and referral to treatment which one psychiatrist recognized as "a service similar to a psychiatrist's domiciliary visit". Six psychiatrists observed that the service saved them time or relieved them of work. Evidently those psychiatrists who were major users of the service accepted (and indeed welcomed) a considerable amount of overlap between their own role and that of the community psychiatric nurse.

The service was also said to be relieving family doctors and health visitors of work, but it was not clear how far the community psychiatric nurses' role was thought to overlap with theirs. It was considered that the community psychiatric nurses could do something positive to improve contact and communication (which a number of respondents considered deficient) between the hospital and the general practitioner service, but there was considerable ambiguity and even conflict in the views expressed about how they could do this without creating problems of etiquette and clinical responsibility. The GP's overall responsibility for the patient in the community implied, for some psychiatrists, that he was entitled to expect direct communication from the nurse and to call on the latter's services for his patient. Others objected that this would confuse the direction of the patient's management, and considered that all contacts with GPs should be made via a

psychiatrist. Some GPs were known to be sensitive to what they might perceive as interference in their relationship with their patients; but it was generally felt that serious problems could be avoided if the nurse's function was explained to the GP at the outset. Some difficulties were almost inevitable because of the larger problems of uncertain relationships between the GP and hospital services.

Several senior psychiatrists observed that the community psychiatric nurses had in effect taken over functions which (until the Social Work (Scotland) Act 1968 came into effect) were carried out by Mental Health Officers of the local authority. It was noted however that they were debarred from certain of these, particularly in relation to the police and the criminal law, by their lack of formal status. If some form of official standing were obtained, they might well acquire an extended consultative role in the community, in addition to the informal advice and support already given on a personal basis to certain agencies.

10.3 The respondents' reaction to the service

It should be noted that, because of the basis on which respondents were selected, the people interviewed included the major current utilizers of the service; it was to be expected, therefore, that their attitudes towards it would be favourable. This was borne out by the views expressed and by the interviewer's impressions. The courteous and ready interest of all the respondents clearly showed how highly they valued the community psychiatric nurses' services to patients and to the hospital. There were scarcely enough critical or negative observations to reassure the interviewer that respondents were expressing their opinions freely. It should be observed that most respondents' experience was necessarily limited to working with perhaps two or three nurses and to the practice of one or two clinical teams. There did in fact appear to be marked differences in the roles played by community psychiatric nurses in the various teams - determined no doubt in part by the nurse's personality and her own and others' conception of her role, but also by the team's functions, the type of patients, and the availability of social workers and other staff.

It became apparent that psychiatrists valued the service most as a means of access to information and a medium of contact with people and events outside the hospital. It "improves the hospital's awareness" of what was happening to patients in the community, and, by providing reliable observations of behaviour and situations in the patient's home surroundings, it acted as a corrective to distorted perspectives and perceptions acquired in the hospital ward or clinic. By its mobility it enabled psychiatrists to compensate partially for their own limited freedom of movement. Standing in an intermediate position between hospital and community resources, it was seen by some users as a link with community services and by others as a welcome protection from the need to make direct contact with them. The two outside respondents, for their part, saw the service as making the resources of the hospital readily available to them with a minimum of formality. Psychiatrists felt that the community psychiatric nurse had greatly improved the hospital's follow-up service to patients, and had succeeded in reducing the frequency of readmissions and facilitating earlier discharge.

It was noted by a number of respondents that in following patients on to their home territory, nurses were operating in a relatively isolated and vulnerable position, without the support, protection and authority afforded by the hospital environment. They were called on to take decisions, sometimes in situations of urgency or crisis, concerning people who might be a danger to themselves and others. This placed on them a considerable burden of responsibility, and called for qualities of initiative and flexibility as well as for sound clinical judgement solidly based on experience of all types of psychiatric illness. The majority of respondents thought the level of responsibility greater than, or at least equal to, that carried by trained nurses in a ward setting. The community psychiatric nurse was also acknowledged to exercise greater autonomy in her work and was expected to use her own discretion about matters which in hospital would require medical sanction. The situation demanded that the nurse should have ready access to consultation and supervision from psychiatrists and nurses "to give them support, to let them feel they have the backing of the hospital .... It is not fair or right that the nurse should be on her <u>own</u> caring for a patient. The Community Nursing Unit is very much a co-operative thing with the doctors".

Systems of communication about cases referred to the community psychiatric nursing service were discussed. Most respondents were satisfied that referrals were (or at any rate could be) adequately discussed with the nurse. One respondent suggested that objectives needed more careful definition, and that an explicit statement of aims in the form of a referral letter should be introduced as a regular practice. People were less satisfied, generally, with information about the nurses' work and the cases in their care. Up-to-date written records, where they existed, were not readily accessible to the others concerned. The retrospective summaries periodically prepared by the nurses for patients' case-notes were of little use because they were filed without others having a chance to read them; one psychiatrist suggested that they should be circulated to clinical team members before being placed in the case-notes. An oral report had been given in nearly all the cases discussed at the interviews; but these related to recent referrals, while the concern seemed rather about long-term cases. Clinical team meetings in theory provided an opportunity for members to keep informed of the community psychiatric nurse's activities, but in practice these meetings dealt mainly with in-patients.

Some respondents did not think that there was enough opportunity for patients and community psychiatric nurses to become acquainted before the nurse was asked to undertake the patient's care. Everyone agreed that patients should not be made to feel they were being 'dumped' from one service to another, but there was some doubt whether this was achieved within the present system of team attachment.

A few psychiatrists quoted difficulties in identifying and getting in touch with the appropriate nurse for a particular case. Several wanted an on-call service, available at evenings, weekends, and holidays, when staffing levels were low and help with emergency situations would be specially useful.

Difficulties of a more fundamental character appeared to have arisen from uncertainties about the community psychiatric nurse's appropriate role. These had led in some instances to an aimless dispersion of the nurse's time and energy in activities which, though 'helpful', did not employ her skills effectively. Covert conflict had been noted between staff groups over demarcation of functions and

"who the patient belonged to". This applied not only between nurses and social workers, but between ward and community nursing staffs. The differentiation of roles between nursing and social work could only,in the opinion of three senior psychiatrists, be successfully accomplished by nurses and social workers themselves; these doctors were reluctant to find themselves asked to adjudicate. The social worker felt that some joint discussion of the problem was overdue. It had not been posed in an acute form because there was generally more than enough work for all available staff; thus the debate had so far been allowed to go by default.

As regards the differentiation of ward nursing from community psychiatric nursing most respondents accepted the status quo in its essentials, although both of the ward charge nurses favoured an adjustment of boundaries to allow ward staff to participate in the processes of admission, discharge and the early stages of after-care. However, three senior psychiatrists favoured the complete integration of hospital and community nursing staffs within the clinical team structure, either with all nurses working in-and-out in both ward and community settings, or with certain members of a ward team designated to undertake work in the community. It was felt that complete integration of all aspects of nursing was the only way to achieve real continuity of care, and that closer involvement with the clinical team would enable nurses to handle a wider range of clinical problems in the community. Nurses would enlarge their skills and would be less prone to become dependent on the hospital environment. It was suggested that, in spite of the administrative problems, it would be worth trying out different ways of deploying the nursing staff in one or two clinical teams.

10.4 SUMMARY

21 users of the service (16 psychiatrists and 5 others who referred new cases to the community psychiatric nurses during the study) were interviewed as to their reasons for selecting the service, their view of its functions, and their general experience of it.

Reasons for selecting the service were primarily explained in terms of nursing skills acquired in hospital - communicating with disturbed people, observing and assessing mental states and clinical needs (especially where organic factors were involved), regulating drug regimes and dealing with crisis situations - but other factors appeared to exercise a considerable influence, including attributes of the patient (loneliness, immobility) or of the nurse (mobility, local knowledge, promptness, ready accessibility through attachment to the clinical team). The functions of the service were described by most respondents in terms of after-care and supervision, clinical observation and assessment, and supportive nurse-patient relationships. The service was particularly appreciated as a link between hospital and 'community' services. Overlapping functions between nurses and psychiatrists caused no problems, but there were anomalies in the differentiation of nursing and social work roles. Conflict appeared to be largely centred round questions of legitimacy and control over the management of cases - between psychiatrists and GP's, and between ward and community psychiatric nurses.

SECTION 11: GENERAL PRACTITIONERS AND COMMUNITY PSYCHIATRIC NURSES: EXPERIENCES AND OPINIONS OF GPs

It was expected, or at least hoped, that one of the functions of the community psychiatric nurse would be to improve communication between the hospital and general medical practitioners and to foster "continuity of care" by helping to coordinate policies and approaches in individual cases. This expectation was expressed during the preliminary stages of the study by members and chief sponsors of the service, and was repeated in a number of the interviews with users of the service within the hospital (see Section 10). Accounts of other community psychiatric nursing services have laid stress on the need for contact with GPs who, in theory at least, exercise a co-ordinating role and are responsible for all aspects of the health and medical care of individuals in the community (Greene 1968, Stobie and Hopkins 1972, Henderson et al. 1973). The GP is normally a 'clearing house' for information about the care of individuals from hospitals and other services in the community. Of all agencies it is the GP who could expect to be kept informed of activities and findings of community psychiatric nurses, particularly in cases where drugs are being administered and supervised by the nurses.

It became apparent, however, that contacts between GPs and participating nurses, whether by formal or informal means, were much less frequent than the researcher had been led to expect. Analysis of data from interviews with the nurses showed that during the six-month study period nurses had been in touch with GPs in only 14% of the cases discussed. Contact with GPs generally seemed to occur in the context of a disturbance or deterioration in the patient's condition. Writing about the service and its functions, the nurse then leading the team stressed in general terms the need for liaison with other health and social services outside the hospital, but made no specific mention of GPs (Nickerson 1972).

Traditionally, the duty of advising and informing family doctors about the care of their patients falls on their professional medical colleagues in hospital; but no routine arrangements existed at the Royal Edinburgh Hospital for psychiatrists to pass on reports to family

doctors about the nurses' activities or findings. (Several psychiatrists had suggested - see Section 10 - that they themselves were not adequately informed). No obligation had been transferred to the community psychiatric nursing service to share in the task of informing GPs. Nurses would telephone GPs but felt it was "not their job" to write letters to them, particularly if the prescription of drugs was involved. In most cases nurses felt no need for periodic consultation with GPs, although a few psychiatrists and GPs welcomed this. As often as not, if a nurse felt that some aspect of her patient's condition required the GP's attention, she would not get in touch with him directly, but would ask a psychiatrist to discuss the matter with him. (This was expected by a minority of psychiatrists - see Section 10). It seemed likely therefore that most GPs would not be well aware of the nurses' activities.

It seemed useful to investigate how the community psychiatric nursing service was regarded by this key group in the community health services. The primary aim was to find out how much they knew about the activities of the service, both in general terms and in particular cases, and to see whether, from the GP's angle, the existing methods of communication seemed to be functioning adequately. Secondly, in view of the impending reorganization of the health service and the changes which it might bring in relationships between hospital and community services, enquiry was made about the working arrangements which GPs would consider appropriate.

11.1 Method of Enquiry

It was decided to focus the enquiry on cases in which the GP could reasonably have been expected to know something about the activities of the community psychiatric nurse. Accordingly it was decided to exclude cases in which the patient was seen only or mainly at the injection clinic, because GPs might well not associate this with the community psychiatric nursing service. Cases were excluded, also, in which the nurse was only involved on an *ad hoc* or short-term footing. Inspection of the data schedules confirmed that such cases were excluded by adopting a criterion of at least four home visits by the nurses. The patients' GPs were identified from the hospital records, and separate lists were drawn up for sample and non-sample cases.

Interviews were sought from six GPs from the non-sample list. After unstructured, exploratory discussions with these doctors, a list of questions was developed for use as an interview guide (Annex 4/7). Twenty-four doctors were selected by a random method from the sample patients' list. They were approached in the first instance by a letter explaining the project, followed by a telephone call requesting an appointment. All of the doctors approached agreed to be interviewed. Some of them had more than one patient among those visited.

It was found at interview that one patient had changed to another doctor before the dates at which the nurse's visits took place, and that another had in fact been attended by a partner of the doctor who was interviewed. These interviews have not been included in the analysis of the results, and a further two doctors were selected, by the same method, to replace them.

The interview topics were substantially covered in the six exploratory interviews, and the results of these have therefore been included in the analysis, making a total of thirty interviews.

All but one of the interviews took place in the doctor's consulting room and (though for obvious reasons the researcher tried to avoid this) many were in the course or at the conclusion of a 'surgery' session. The exception was one in which the doctor preferred to be interviewed at his home in the evening. To facilitate accurate recording, a tape-recorder was used with the respondent's permission, unless he was obviously disturbed by it. The topics included in the interview guide (Annex 4/7)were covered at each interview as far as was appropriate and possible.

11.2 The Findings*

The topics discussed are reviewed below in three main groups:-

a) how much did doctors know and what were their general impressions about the existence and functions of the Royal Edinburgh Hospital's community nursing scheme?

b) how much did the doctors know about nurses' activities in relation to individual cases, and what were their reactions?

c) did doctors feel a need for a community psychiatric nursing service, and what working relationships between the service's staff and GPs did they think appropriate?

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* The subject matter does not lend itself to statistical tabulations; and, to avoid confusing the reader, the writer has generally refrained from quoting the exact number of respondents whose views on any particular topic are referred to in the text. Where proportions (a quarter, a half) are quoted, these are correct to within one digit. 'A few' generally means less than a quarter of the total number of respondents; 'several' or 'some' means between a quarter and a half; 'many' means more than half, and 'most' means three-quarters or more.

(a) Existence and functions of the service

Of the thirty doctors interviewed, half were unaware that the Royal Edinburgh Hospital had nurses assigned to provide a community service, and a few others said they were only vaguely aware of this. Several doctors had an idea that nurses from the hospital did occasionally undertake after-care with discharged patients, but some thought these were ward nurses and others that they were health visitors attached to the hospital staff. Of those who were aware of the existence of the service, only one said he had ever received any explanation of its functions and this had been from a member of the staff whom he happened to meet in a personal context. Two of the doctors who were unaware or vaguely aware, said that on being reminded they recalled some explanation being given. Some doctors asked for more information, but most expressed no special wish to know more. (There seemed to be no relationship between the doctor's desire for further information and his previous awareness of the service's existence).

In all, just over half of the doctors, a few of whom had not previously been aware of the service's existence, were prepared to express some conception of its functions. About half of them described this as "follow-up" or "after-care" without defining this further except by such phrases as "keep an eye on" or "see how he is coping". A few added riders to the effect that this work was essentially hospital-orientated. Almost half of the doctors defined the service's function in terms of observation and some of these added referral for treatment, either to GPs or to hospital. A few doctors suggested that the nurses were relieving or acting as substitutes for the GP. One of these suggested a role directly parallel with that of a health visitor with emphasis on preventive observation, referral for treatment, and attention to social problems. Only two doctors mentioned giving emotional and social support to the patient or family. Another doctor felt that the community psychiatric nurse should have a special role in assessing family situations and patients' effect on them; he believed that additional training

should be given to equip nurses for this. Only one doctor defined the service's functions in terms related to traditional basic and technical "nursing care" - supervising drugs and injections, taking an interest in the patient's general well-being, diet etc., giving active help in daily activities and taking care of the elderly and socially isolated. One doctor thought the nurses' main job was to operate the injection clinic; but, although giving injections of a depot Phenothiazine was associated in a number of doctors' minds with the community psychiatric nursing service, not all of them seemed to realize that there was a connection between this service and the clinic.

(b) Relations and reactions in specific cases

GPs proved to be very ill-informed about the activities of the service in individual cases. A third of the thirty doctors were unaware of the fact that their patients had been receiving home visits from any member of the hospital staff. A few said they had been informed at some time but did not know whether the service was still being given; several others said they knew that somebody from the hospital was visiting but did not know who (it was usually assumed to be a social worker). Less than a third answered without qualification that they were aware of what was happening.

Of the twenty who were fully or partially aware, just over half said they had been told of the visits by the patient himself or by a member of the patient's household. The others were equally divided between those who could not remember how they knew, those who had been informed by a psychiatrist or "the hospital", and those who learned through contact with the community psychiatric nurse.

A few doctors could remember being in personal contact with the visiting nurse, or were not sure, but half, although they were fully or vaguely aware of the nurse's visits, said they had received no contact from the nurse. In four of these cases, however, the nurse had told the researcher that she had approached the GP by telephone or letter during the study period.* One doctor, who professed to know and appreciate one of the nurses, described her in terms which could not possibly apply to any member of the team (" a charming coloured girl").

*Three out of these four practitioners worked in partnership or group practices, so that the matter could have been dealt with by a colleague.

Asked how they reacted when they heard that these nurses were visiting their patients, half of the doctors positively welcomed this, or at least had no objection("If the hospital can spare the nurses .....").

A few reacted negatively because of the absence of prior notification or consultation, or because they felt that the nurse's methods or objectives might not be appropriate and should be clarified. One was doubtful of the competence of psychiatric nurses, and another felt that, in general, a nurse's home visit was a poor substitute for an interview with a psychiatrist - "the partly-trained substituting for the fully-trained".

The remaining third said, with varying degrees of heat, that, though they accepted the nurses' intervention, they wished to be kept informed of what was happening. Several commented that without this there was a serious risk of conflict and sheer muddle between the approaches and policies of the hospital staff and the general practice team. A few doctors stressed their own knowledge of the patient and influence over him, and implied that these were being undervalued.

In spite of their moderate language, it was obvious that some doctors were angered by what they regarded as the intrusion of a group who were not answerable to them and of whose activities they had never "officially" been informed. One doctor described how he had received a telephone call late one evening from a member of the service who was concerned about one of his patients. "As there had been no communication <u>about</u> these nurses from the hospital, nor between the nurse and the practice, the immediate reaction was one of antagonism. One felt it was unofficial - or indeed that it was interference". This conversation seemed to have achieved little, except perhaps to discourage the nurse from consulting GPs.

Several doctors judged the service by previous experience of psychiatric or mental health social workers. One said, "They don't maintain their visits ..... 'The PSW will be keeping in touch' ..... that's not true".

Doctors were asked whether the nursing service had affected their own contact with the hospital about patients, but the majority had little experience of the service to draw on. Of the minority who offered comments, half seemed to be doubtful or confused about the type of

staff to whom their previous experience related. Only two were entirely happy with their own experience of the team's work, and the others complained of poor communications. One doctor instanced an occasion on which he wanted to suggest an adjustment in a patient's injectable drug regime. Although he spoke to a community nurse and a psychiatrist, neither would respond to his suggestion or take any responsibility for dealing with it. The psychiatrist had disclaimed any knowledge of the matter and of the nurses' activities. This doctor gained the impression that the responsibilities of nurses and psychiatrists in this area had not been defined,* that communication between them was non-existent, and that in consequence neither was prepared to do anything. In his view, based on this and several other incidents, far from improving communication between GPs and the hospital, the intervention of the nursing service only confused and frustrated it and prevented GPs from making effective use of the hospital service.

This doctor pointed out that the community psychiatric nurses provided a new means by which, by-passing conventional referral procedures, patients could be admitted to the hospital. In these cases the usual methods of communication with GPs were also by-passed but had not been superseded. In consequence, he suggested, patients could be, and repeatedly were, admitted and sent home without the GP's knowledge. In such cases, continuity of care was adversely affected.

Most respondents had too little experience of the service to comment on its contribution to continuity in the care of patients. Out of the few who did discuss this point, two thought that a continuous personal contact with a member of the hospital staff was helpful to the patient, but noted that this process did not include the GP. The rest thought that the nursing service had not helped continuity of care. It was suggested by more than one doctor that this was basically because the community psychiatric nurses appeared

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* Note

The difficulty may have arisen from the ambiguous division of responsibility between ward psychiatrists and the injection clinic doctors. The allegation of poor internal communications seemed to have been justified.

to exert no influence on decisions taken within the hospital about patients' treatment or disposal.

(c) The need for a psychiatric nursing service in the community

Surprisingly, in view of the reservations already described, three out of four general practitioners definitely said that psychiatric nurses were needed to work in the community. The emphasis was placed more, however, on psychiatric experience in general than on a specific nursing role. "With the demise of the old community-based psychiatric social worker, after-care is waiting to be done by somebody who has a psychiatric training". It was clear, however, that many GPs were unfamiliar with the training and roles of workers in the psychiatric field; several commented how difficult they found it "nowadays" to understand the psychiatric services. The need expressed by many doctors was for workers who could understand and handle people with severe psychiatric or personality problems; it was felt that district nurses and health visitors without psychiatric training did not, on the whole, tolerate such situations well, and a few doctors admitted to themselves being out of their depth. A need for social skills and for assessment of social conditions was also expressed by a few doctors: one said "We need a psychiatric nurse-cum-social worker who could look after everything".

The need for "follow-up" and "continuity of care" was seen, in a majority of cases, from the hospital's angle. These doctors appreciated a service which relieved them of involvement specially with cases in which chronic or recurrent psychiatric problems were prominent. "People who are liable to become psychotic .... who in the past would have been in and out of hospital ..... for this type of patient ..... it has given me a tremendous feeling of confidence that the hospital was still taking an interest". There were a few, however, who obviously themselves wanted to work with psychiatric nurses and to benefit from their particular expertise.

The views of the minority who doubted or denied a need for a psychiatric nursing service were varied and interesting. One doubted whether nurses with psychiatric training only were competent to do domiciliary work, because he felt they would fail to

observe or appreciate organic factors in the patient's condition. Another felt that any nurse could give the necessary 'support' to patients in their homes, unless they became so disturbed that they required treatment by a psychiatrist. A third considered that psychiatric nurses were not required, because any "practice nurse" - and indeed all nurses - should be adequately trained to recognise patients who were in need of psychiatric treatment. Another doctor preferred health visitors because they worked from a "community" base and were trained in "social" skills. Two GPs thought that the work involved was more appropriate to social workers, (but one of them believed that all psychiatric social workers were also trained as nurses). The other thought that little "nursing" was involved: nurses were for people who were "ill" and their services were more urgently needed in hospital. Finally, one GP doubted whether the results of this "time-consuming and thankless" work would justify the effort expended, and felt that it required further evaluation.

Doctors' views were sought on how a community psychiatric nursing service should be linked to the hospital and general practitioner services. There was an almost equal division of opinion between those who thought that the nurses, as part of the specialized psychiatric services, should be (and were) accountable primarily to the hospital; and others who felt that their primary responsibility should be to the GP, shared between the GP and the hospital psychiatrist, or transferred from one to the other according to the progress and status of the patient.

Regardless of their views on the nurses' line of responsibility, practically all the GPs said they wanted to receive some form of direct communication from them about the patients they were seeing. Only one doctor thought no reports were needed and a second felt that he would prefer to hear from a psychiatrist rather than direct from a nurse. A few doctors thought that periodic written reports, supplemented where necessary by personal consultation, would be adequate. The majority were not in favour of adding to the volume of paper they received; a few only wished to hear from the nurses if there was something special happening, but the majority wanted periodic personal consultations. Several doctors said that they would welcome the community psychiatric nurses' attendance regularly or occasionally

at the practice meetings or conferences attended by 'attached' nurses and health visitors; it was implied that they would then be available to give consultation and active help with patients of the practice in addition to the patients already referred to them.

At the present time most GPs thought that the service was only available for patients who had been referred to the hospital, and that it was not open to themselves to call directly upon it; but a majority said that they would like to have direct access to such a service.

A few doctors suggested, in terms remarkably like those used by psychiatrists in a similar context (see section 10), that they would be more likely to "think of" using a community psychiatric nursing service if they were personally acquainted with the staff and saw them from time to time. Another said, "They work with me because I took the trouble to get in touch with them". It was not clear whether the implication was that personal contact would simply jog the doctor's memory, or would enable him to exercise some control.

A number of doctors found it difficult to define what sort of relationship they felt would be appropriate between the community psychiatric nursing service and their own teams. Only three felt that no relationship at all, formal or informal, was called for. Some defined the desired relationship in terms of practice attachment on the model of district nurse or health visitor attachment, but others recognised that the number of potential 'clients' in any one practice was probably too small to make this a feasible proposition. About half of the doctors talked of more informal links involving a commitment on the nurse's part to consult personally with her clients' GPs from time to time, or, at a further remove, to keep the GP informed. One doctor regarded this as a self-evident duty: "A nurse with the least sense of responsibility, who is visiting a patient, would have found out who that patient's GP was and would have been in contact with him".

11.3 Interpretation of Findings

The researcher interpreted the results of this enquiry in the following sense:

i. GPs were ill-informed about the existence and function of this service, its role had not been defined for them and most of them felt it was not available to give them direct help. Accordingly they regarded it with a certain latent antagonism as potentially in competition with themselves and their teams.

ii GPs were ill-informed about nurses' activities in individual cases; their chief source of information was the patient himself. GPs felt they had no control over the situation and that they were being excluded from the care of "their" patients. The anxieties raised were expressed as predictions of conflict and confusion in treatment policies, although few actual instances of such problems were quoted.

iii Many GPs felt also that they and their practice teams were not capable of adequately handling cases of psychiatric disturbance. Unable to get direct support from hospital services, some of them tended to withdraw from involvement in these cases.

iv Those GPs who expected to be personally consulted or informed about the care of "their" patients, felt that the initiative in this should be taken by the psychiatric service.

v Most GPs conceived the role of the existing community psychiatric nursing services as narrowly limited to the supervision and return to treatment where necessary of discharged hospital patients.

vi A minority of GPs felt a need for a specialized service possessing a combination of social and psychiatric skills to cater for the mentally disturbed in the community. They hoped that the psychiatric nursing service might fill this need.

vii Most GPs had little appreciation of the training and skills of workers in the psychiatric field in general, and of psychiatric nurses in particular. Few could assess what could be expected of a psychiatric nurse, what situations she could deal with and what sort of support she was likely to need. GPs' referrals to a community psychiatric nursing service could be expected, therefore, to be ill-defined and sometimes inappropriate. Sources of consultation and support for psychiatric nurses in the community are likely to be found chiefly in the hospital service.

11.4 SUMMARY

This section reviews the opinions of 30 general practitioners selected at random from those who had patients in the care of the community psychiatric nursing service.

The respondents were not well informed of the activities and functions of this service, or, more generally, of the training or skills of workers in the psychiatric field. Communication between doctors and members of the service about patients whom they shared had been very limited. This created some anxiety and antagonism. A minority of GPs favoured a general-purpose psychiatric visitor in the community with a combination of social and psychiatric skills. Doctors were unlikely to make use of their services, however, unless they had personal contact with them.

SECTION 12: NURSES' CONCEPTION OF THEIR OWN FUNCTIONS

Towell (1975) has shown that descriptions of what psychiatric nurses do are difficult to interpret without an understanding of the perspectives which influence their approach to their work; his study concerned nurses in hospital wards.

In the present study an attempt was made to identify the perspectives used by the community psychiatric nurses in considering their own work with patients and clients, by asking them to describe their aims and methods in respect of particular cases. Questions on these matters were included in the first research interview about each case. It was hoped that the nurses' responses would indicate how they interpreted their functions, how much weight they gave to different aspects of their work, and what boundaries they set for their own activities. Further information was also expected from nurses' discussion of the problems of patients and relatives and of the action which they took in relation to these.

Questions about nurses' aims and methods were worded as follows:-

> "What are your most important aims in the work you do with (the patient)? How do you go about this? (Could you describe your methods?)"

Responses were recorded verbatim as far as the interview situation allowed. Prompting and supplementary questions were used to clarify incomplete, diffuse or muddled answers; in such cases the responses might be summarised or condensed in the process of recording. The total number of interviews was 111. Responses about aims and methods were secured in all except 2 cases.

Aims were often expressed in vague or general terms:

"Give her support in the community".

"Keep him out of hospital".

Enquiry about methods generally elicited a more specific statement of how the nurse expected to behave; for instance:

> "Give her support .... (How?) .... an outlet to talk about her hallucinations which she does not like to mention to most people".

> "Encourage her to get a job and to start socializing .. (How?) ... by talking to her about jobs and what sort of work would be suitable. Give her an ear for her troubles".

"Pull her through this bout of depression - get her on her feet again. (How?) Sit and talk to her .... encouragement .... get her to talk about herself".

The aims expressed were largely conservative; nurses seemed more inclined to see themselves as maintaining the status quo than as introducing material change in the patient or the situation:

"Go on giving support".

"Keep a personal relationship".

"Make sure he remains symptom-free".

"Keep him going in the hostel".

"Keep him working ... clean .... socially viable ...."

"Support her in the community at her present level".

"Keep an eye on her mental state - ensure that it does not deteriorate ..."

"Support her in her present circumstances ...."

Those aims which were stated in more specific terms were also mainly concerned with the maintenance of some routine:

"See that he is given his Modecate ....."

"Encourage him to attend the Day Hospital ....."

It was apparent in some cases that the nurse had started with more ambitious objectives for the case, but that after repeated disappointment these had been scaled down to represent supposedly more realistic aims for the patient:

"I have given up trying to help her. I can't find any accommodation which will take her - I have tried every hostel in Edinburgh. So long as she is around I am willing to go and see the home situation if she complains, and try to smooth things over".

"Our objectives are now limited to offering him Modecate and giving him the choice of accepting or refusing".

"He will not attend the Day Hospital or schizophrenic rehabilitation programme. Just keep up his Modecate and respond to crisis situations as they are brought to our attention by the family. Home visits when called for .... allow the family to 'ventilate' their feelings".

"Try to stimulate her to look for a job - but I know it is an absolute waste of time".

In other cases aims were deliberately restricted because problems were seen either as not susceptible of improvement, or as more

appropriate to another type of worker:

> "I make sure she gets her Modecate. She doesn't need support. There is a lot of tension with her parents but I don't think one can help ..... they have probably always been like this".
>
> "Home visits when required but for injections only. I avoid involvement in family quarrels - it is better for one person (i.e. Dr. X) to handle them".
>
> " I do not have time to try and socialize him and I doubt if his personality would allow success. We see him at the clinic. If I visit him at home he doesn't let me in".

The nurses rarely used psychodynamic terms, but there were a few cases in which the use of such concepts was implied:

> "Raise the wife's self-esteem".
>
> "Interpret very superficially what her behaviour is doing to her relationship with her sister".
>
> "Take over her dependency needs to reduce her dependence on the ward."

Most functions were expressed in every-day language and common-sense terms.

Taking into account both the aims and the methods described by the nurses, a list of the main types of function mentioned was drawn up:

Prevent relapse, control symptoms

Stimulate physical and/or mental activity

Advise on/encourage improved management of patient

Help patient to reach or maintain a socially-acceptable level of behaviour

Help patient to reach or maintain economic and social independence and self-support

Reduce stress by modification of environmental conditions, providing services etc.

Improve emotional adjustment through a therapeutic relationship

'Crisis intervention'

Give 'support' or social contact

Maintain prescribed treatment/investigate failure to comply

Maintain communication or supervision

Assess emotional/mental state or behaviour, and refer for help as necessary

Maintain liaison with others concerned with the patient or household.

Other types of function which were relatively rarely mentioned concerned assessment or care of the patient's physical health, attempts to modify interpersonal relationship problems, assessment and referral of social and environmental problems, and negotiation regarding the advisability (or otherwise) of admitting the patient to hospital.

Unsuccessful attempts were made to devise a list of categories which would prove reliable when used by the researcher and others to classify the content of these responses. Several versions were tried out with the help of four others - a social researcher and three nurses, all with experience or knowledge in the field of psychiatry. Agreement between the users was consistently poor; the best level of agreement reached was 55%. The problems appeared to arise from the vagueness of the terms used by respondents, which could often be interpreted with apparent validity in more than one way. Eventually all these attempts were abandoned, and a simpler classification into five general categories was adopted and applied by the researcher only.

The results represent the researcher's understanding of the data: their reliability has not been tested.

Each of the five categories used covers a wide range of specific functions:

1. CLINICAL: concerned with activities and perceptions based on concepts of psychiatric illness and treatment. They include instrumental nursing functions such as clinical observation of the patient, advice on nursing management and regulation of treatment.

2. PSYCHO-SOCIAL: concerned with modes of interaction between individuals and groups and with therapeutic use of relationships to improve emotional adjustment and to modify patterns of behaviour.

3. ENVIRONMENTAL: concerned with intervention in patients' material and social circumstances (other than relationship problems) whether directly or by referral.

4. INTERNAL LIAISON: concerned with coordination and communication activities relating to hospital staff and the hospital as an organisation.

5. EXTERNAL LIAISON: concerned with coordination, communication and consultation activities relating to extra-hospital agencies and staff.

The following examples of responses assigned to each category have been chosen at random. The percentage figures in brackets show the percentage of the total number of cases to which the category was applied (see also Table 12.1).

1. CLINICAL (61%) "Maintain Modecate treatment".

"Supervise her mental state and get any appropriate help for her"

"Maintain her current condition".

"Make sure he remains symptom-free".

2. PSYCHO-SOCIAL (60%) "Discuss her past experiences and how they are affecting her today. Help her to overcome her apprehension ..... I took my cue from Dr. X and am following on but in a less intensive way. She ..... feels she can also discuss these things with me".

"To get husband and wife to communicate about their problems and come to some decision about the future. Get both of them together and make them talk about their marriage. To get the situation out in the open air."

"Great patience and long persistance are required to make any change. I see him almost every week and chat to him about all sorts of things .... A contact with somebody from outside who bothers about him".

"To be somebody she sees fairly regularly ..... a friendly interested humorous approach. To let her express her feelings, to give her somebody she can talk to at length without interruption".

3. ENVIRONMENTAL (19%) "Encourage him to get out a bit more. I have taken him out - after long persuasion".

"Possibly try to get him admitted to a Corporation old peoples' home".

"Keep her going in her own home as long as possible ..... If I find she's in a heap on the floor or living in a guddle then we'll have to take steps to get her admitted somewhere where she'll be taken care of .....Every time I go she produces a problem but I solve that and then she's OK again for another few months".

"Make supporting services available e.g. Home Help. See that any responsibility is lifted from her".

4. INTERNAL LIAISON (13%)

"Get him into hospital when he becomes unfit for his present way of life".

"Maintain contact with hospital. Encourage him to attend as a day patient".

"Maintain communication between Miss X and the hospital in a beneficial way. To play the role of advocate for her within the hospital".

"Find out what is going on and report to her doctor in order to prevent things getting so bad that she gets into trouble with the police or does something exceptionally impulsive".

5. EXTERNAL LIAISON (17%)

"Liaise with G.P."

"Keep him in the community as long as possible by ..... supervising his present (very protective) environment".

"Contact with Nursing Home staff. Advise if requested on the management of her mental state".

"To refer him to the appropriate people for any social problems".

A few statements could not be categorized under any of the above heads because they were too imprecise or no aims were expressed.

The following are examples:

"Observe the situation periodically in order to take appropriate action if necessary".

"No aims - she is a day-patient and is looked after by Ward N. I chase her up when requested to do so by the ward".

12.1 Findings

The first two categories of function - clinical and psychosocial - were by far the most frequently mentioned, and one or both of them was applied to 92% of cases in the sample. (Of the nine exceptions, seven were phrased in such a way that no category could be applied; the other two cases were of residents in institutions whose own staff undertook their direct care). In one-third of cases both clinical and psycho-social categories applied. 'Environmental' functions were mentioned much less frequently, in about 20% of cases (Table A12/1).

Liaison functions were defined according to whether they related to hospital or extra-mural agencies and staff. There was little difference in their frequency (13% and 17% respectively).

'Psycho-social' functions were broken down according to their primary concern with the patient, his relatives, or with the family group as a whole. In almost one-third of cases a relative or relatives of the patient were mentioned as primary objects of such care - the family group as a whole in 8%, the patient and his relatives separately in 8%, and a relative alone in 12% of cases.

It was found that the type of aim expressed and the settings in which nurse/client contacts took place in any individual case were associated.* Clinically-oriented aims and functions were significantly associated with clinic attendance, and psycho-social aims with extra-mural care (see Table A12/2). It was thought that there might be similar associations between the identity of the people most often seen in each case and the aims expressed; but this expectation was only borne out to a limited extent by the evidence. There was no significant association between the expression of a psycho-social function as such and the presence or absence of family members at contacts; but where psycho-social aims were expressly related to patients' relatives or to the family as a group, it was significantly more likely that relatives were present at a majority of contacts (Table A12/3). There was a trend (which did not reach significance

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* The variation in the number of contacts in different cases (total contacts ranged from 1 to 36) limits the confidence with which these findings can be regarded. Cases in which only three contacts took place during the study periods are treated here in the same way as those with thirty or more. The type of setting characteristic of a particular case was more likely to be reliably represented where the total number of observed contacts was relatively high.

at the 5% level) towards association between clinical aims and cases in which the patient was usually seen on his own; but this was probably due to the association between clinical aims and clinic contact (at which patients were rarely accompanied by relatives - Table A7/4).

Further evidence about the nurses' perception of their functions was obtained from the information which they gave about the patients' 'special problems' (Annex 4/4.4). The predefined list of problems which was presented to the respondents did not relate to a 'disease' model of mental disorder; it referred rather to concepts of maladaptive behaviour and failure to cope. The nurses' responses regarding these problems are not relevant to their clinical functions, but highly relevant to how they defined the 'psycho-social' and 'environmental' aspects of their role.

The list of problems covers a wide range of difficulties from personal emotional difficulties to problems connected with employment, housing, money, conflict with the law and so forth. Respondents were asked to say in each case what problems they had observed, and whether they affected the identified patient, his family members, or both. They were also asked what kind of action they had themselves taken with regard to each problem. Responses suggested that nurses took as active an interest in the problems of relatives as they did in those of patients.

About 600 'special problems' were identified (TableA12/4) of which approximately 75% related to patients and 25% to families. (The problems are arranged in the table in the order of frequency with which they were reported). The nurse's intervention might be by 'direct' methods of care (discussion or practical help), or by referral to another agency, usually after preliminary discussion. Direct methods were used about twice as frequently as referral .

The nurses made no attempt to intervene in about half of the problems recorded, and gave reasons for her inaction in half of these instances. The main reasons given were (a) that the problem was already being handled by some other person or agency or (b) that the nurse considered that intervention was unnecessary or unlikely to be successful. In rather fewer cases, the nurse said that the client would not accept help, or that the problem was inappropriate for her own intervention.

The nurses' responses showed general concern with all types of problem; and, although some individuals defined their functions more narrowly than others, there was little evidence that nurses excluded themselves from any particular area of concern. Exceptions to this general statement are:

(1) Mental disorder in a patient's relative, which in most instances was noted as being handled by another agency.

(ii) Financial and legal problems, and problems of conflict with the law, which were usually referred to another worker (generally a social worker).

(iii) Problems of general health were referred to the general practitioner unless they were considered trifling or imaginary.

Accommodation and loneliness problems involved a high proportion of referrals to other agencies because of the need for specific resources.

Problems which were especially likely to be directly handled by the nurse were those of distress and strain due to bereavement or to patients' upsetting mental state or behaviour. Family relationships (including marital problems) were also in most instances dealt with directly by the nurse; but in a high proportion of cases the nurse did not consider the problem susceptible of help. Personality problems were frequently reported but relatively rarely tackled by the nurse; these difficulties were generally associated with other more specific problems to which the nurse's activity might well be directed.

To sum up, it appears from the data on special problems that the community psychiatric nurses made comprehensive assessments of all aspects of their client's social needs and problems, and that in this process they did not discriminate between the patient and his relatives. In the case of family members, however, consequent action might be modified because they were not hospital patients. The participating nurses concerned themselves particularly with emotional and social relationsip problems (although their approach to these tended to be pessimistic). They did not refrain from intervening in environmental problems requiring a more instrumental type of help, but they were more inclined to

refer these to social workers whose instrumental functions they tended to emphasize at the expense of the expressive, case-work, aspects of their work. Conventional role-prescriptions were observed in the case of other health service workers.

12.2 Interpretation of findings

The main issues raised by these findings concern:-

(a) the relative importance for the nurses of the aspects of their work involving direct care, compared with the liaison and referral functions

(b) the balance between the clinical and psycho-social aspects of direct care, and the extent to which they were associated with different working settings

(c) the vagueness of the nurses' objectives in the care of patients and lack of specificity in their definitions of their functions

(d) the arbitrary way in which they defined the boundaries of the role especially in relation to social work

In virtually every case the aims of the nurse were largely oriented towards direct care through the exercise of clinical or psycho-social functions. These were by no means mutually exclusive, but occurred separately more often than together. There was a significant tendency towards association with different working environments - a clinical orientation being (predictably) linked with cases dealt with at the nurses' injection clinic, and a psycho-social orientation associated with other settings, notably of course the patient's home. 'Environmental' services and liaison functions were less prominent, and no association with any particular setting was apparent.

Clinical functions and methods were described in the appropriate technical language, but psycho-social and other types of function were expressed in 'lay' terms understandable on a basis of common sense. A lack of theoretical basis for the interpersonal aspects of nursing care, noted by Altschul (1972), was manifest in the nurses' responses. Objectives of care were excessively broad and non-specific to a point at which it was often virtually impossible to say whether or not the objective had been met. In the writer's view, this lack of specific purpose and direction in the nurses' care was one of the reasons (and a powerful one) why it was so seldom found possible to bring their connection with a case to an end, because they could not at any stage establish progress, success or failure.

There seemed to be a difficulty in defining non-clinical situations, needs and problems in terms of general concepts which could be used as a basis for a rational selection of methods of care, and for the evaluation of results. Nursing practice seemed to be based on a rather haphazard application of intuitive insights and individual experience. Although this may at times be highly successful, it is essentially a non-professional kind of practice, depending on personal aptitude rather than on the application of a body of knowledge by reference to explicit principles.

12.3 SUMMARY

This section deals with analysis of nurses' descriptions of their aims and methods in relation to particular cases. A broad classification into five aspects of psychiatric nursing intervention was used - clinical, psychosocial, environmental, internal liaison and external liaison. The results showed an association between types of care and the settings in which they were given; and a bias in favour of direct forms of care. Nurses' accounts of the action which they took in relation to patients' social and environmental problems are also considered. Some issues are raised concerning nurses' interpretations of their own and other professionals' roles.

PART III: SUMMING UP THE STUDY

SECTION 13: REVIEW AND SUMMARY OF THE FINDINGS

This project was essentially a descriptive case-study of a working situation. The intention was to analyse and describe the functions and skills exercised by a particular group of nurses in a particular setting, and to show how these were modified by factors in the situation. The setting was scarcely typical, and it would be misleading to base general conclusions about the nature and functions of community psychiatric nursing services on the evidence of this particular case. Still less did the study set out to prove the value of such services in terms of efficiency or effectiveness. However, a case study may provide useful insights into other situations through informed judgment and critical appraisal of this description. The validity of the appraisal presented here depends upon the selection and interpretation of the significant data. The methods used in the study impose their own limitations; much of the information produced was quantitative, recording events and actions without explaining their meaning and purpose. Interpretations of such data in terms of other, qualitative findings, rest largely upon inference, not upon proof of relationships between 'hard' and 'soft' data. With due acknowledgment of the inevitable subjectivity of these aspects of the analysis, it remains for the research worker to review the evidence and to draw attention to those features which, in her judgment, are most instructive.

Study of the literature, and of the data presented in sections 5 to 12 of this report, suggests that the orientations and activities of the community psychiatric nurses who participated in this study were influenced and ultimately determined by multiple factors. The nurse's own conception of her role and proper functions depend upon the conceptual models of mental disorder, psychiatric treatment, community care and nursing functions which she uses. According to the literature, these concepts are related to the nurse's institutional base and particularly to the prevailing ideological positions of her psychiatrist colleagues (page 28). The nurse's performance of her tasks is also influenced by her perception of her patients' needs and characteristics, which help to determine her aims in regard to the case. The characteristics of the nurse's clientele will differ according to her operational base, the referral policies of her colleagues, and

her own attitudes about the type of cases which she ought to handle. The nurse's work is influenced, lastly, by the persons whom she meets in the course of caring for patients, by the environments and situations in which nurse-patient contacts take place, and by the specific functions which she is asked to undertake when cases are referred to her. The writer has tried to show in schematic form how these factors are inter-related (Figure13/1).

The way in which some of these factors operated in the case of the Edinburgh community psychiatric nursing service is discussed in this section.

13.1 Frames of Reference in relation to Hospital and Community Settings

The work of the nurses in this service, according to their own reports, was modest in its objectives and conservative in its methods. Supportive rather than dynamic procedures were used. The nurses did not follow the mainstream tradition of social psychiatry in expressing optimistic goals of promoting social learning and social change through constructive intervention in unstable situations. They were more concerned with alleviating immediate distress, maintaining patients' existing levels of functioning, and encouraging families' tolerance, by supportive techniques and procedures of 'direct influence'. Techniques of confrontation and clarification were linked primarily with the establishment of authority and control in critical situations; they did not appear to have been employed in order to explore the dynamics of behaviour. Aspects of regulation and control of patients' behaviour formed an appreciable part of the work of this group of nurses.

The content of their activity was related to three distinct areas of function which were demonstrated by the primary linkages of topics and observations in the description of nurse-patient contacts, and by the analysis of nurses' expressed aims and methods. These areas were:

(1) Medical treatment and its effect on individuals and their performance,

(2) Psychological adjustment and social relationships

(3) Socio-economic problems and resources

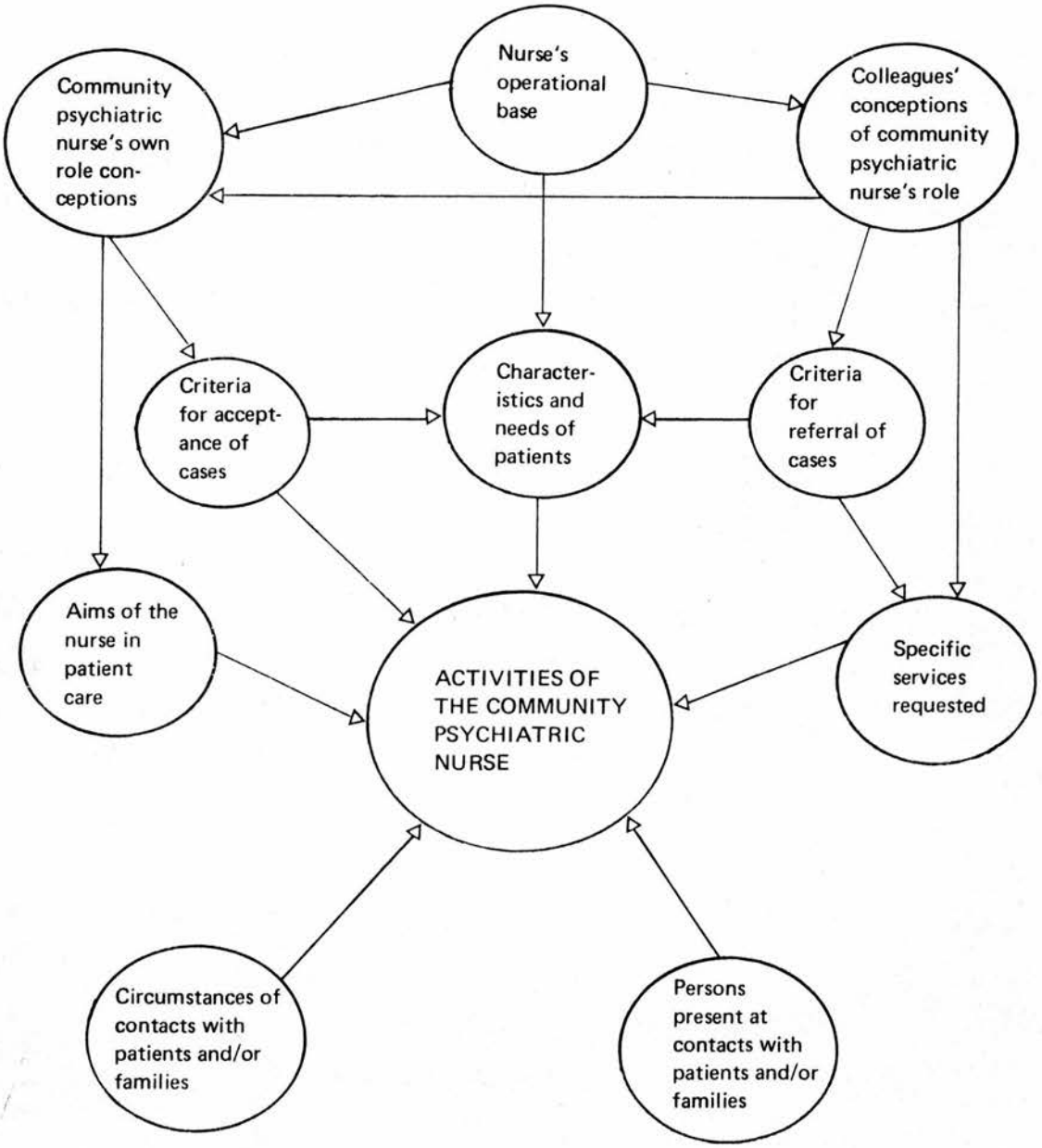

FIGURE 13/1. SCHEMA OF FACTORS WHICH INFLUENCE THE WORK OF THE COMMUNITY PSYCHIATRIC NURSE.

Two distinct frames of reference, one derived from a clinical concept of mental disorder and treatment, and the other from social-psychological or interactional concepts, were used by the nurses in discussing their work in two different settings: their out-patient injection clinic and their domiciliary and community visits. There was no evidence that the different frames of reference were associated with other dimensions of their activities or clientele - for instance with identified patients as opposed to family members.

Domiciliary and clinic care were differentiated by a feature which might be defined as individualized versus impersonal care. At home visits the same nurse was present on a majority of occasions; at the clinic this was the exception. It is generally assumed that a continuous personal 'relationship' with an individual nurse can be helpful to patients (but the writer is not aware of any evidence which proves this to be the case).

Because the process and content of nurse/patient interaction at the clinic was not investigated in the same way as it was at community visits, there was little evidence to show whether and how the two frames of reference were expressed in terms of interaction and activity. However it was clear from aspects of the two situations that the nursing process must have varied substantially between them. The fact that family groups were often seen together at home, and practically never at the clinic, was one; another was the fact that an average home visit lasted seven times as long as an average clinic contact. It became obvious that the range of information about patients which nurses could derive solely from contacts at the clinic was very restricted. In contrast with the stereotyped nurse/patient grouping at the clinic, the social situations and problems presented by home visits and family group interactions were very much more varied, complex and demanding in terms of therapeutic skills and professional relationships.

The nurses' principal functions at the clinic were relatively easily identified. The nurse's concern was to administer treatment as prescribed by physicians; to monitor the effectiveness of the treatment by reference to the patient's clinical condition and current level of social performance; and to inform the responsible psychiatrist or other clinical colleague of any change, deterioration

or difficulty which seemed to require attention. The restricted time available and the formality of the clinic surroundings did not encourage communication except at a rather superficial level. In the patient's home, the nurse was more likely to encounter emotionally-laden communication and problems of personal relationships. Her function in the home was correspondingly less likely to be defined in terms of clinical tasks, observations and responsibilities.

13.2 The Clinical Perspective: A Task-Oriented Concept of the Nurse's Role

The frame of reference within which the nurse arranges her thoughts about mental disorder, whether it be oriented towards organic, psychological or social factors, is likely to exert a strong influence on her perception of the patient and his problems, and to modify her actions and objectives. There is evidence relating to District Nurses' perceptions of their patients which suggests that a clinical perspective has the effect of reducing attentiveness and sensitivity to social problems, which are presumably not seen as appropriate for nursing intervention (Jefferys 1965, pp 91-95).

In defining the functions of the community psychiatric nursing service, some of their professional colleagues within the hospital emphasised a specific clinical task - the administration and control of the new long-acting "depot" tranquillizing drugs. Participating nurses defined their aims in relation to many patients (particularly those seen in the clinic setting) in terms relating only to this task. References in the literature to other community psychiatric nursing services suggest that some have derived their raison d'etre from it.

How did this clinical task come to command so much attention in the context of psychiatric nursing in the community? The introduction in the late 1960s of injectable drugs (initially in the phenothiazine group) whose activity will persist over periods of up to 4 weeks, made it possible to maintain chemotherapy consistently and regularly in the case of many patients who formerly relapsed again and again when they stopped taking medication by mouth. These patients showed one form of the 'revolving door' syndrome, a cycle of events in which the patient required recurrent re-admission to hospital. The use

of the injectable depot phenothiazine drugs made it possible to interrupt this cycle and to maintain in the community patients who might otherwise have become long-term hospital residents.

The first depot phenothiazine to come into general use was, for a short initial period, available only through hospital pharmacies. This fortuitous circumstance helped to create a demand for hospital-based mobile corps of qualified psychiatric nurses. It was felt that these nurses, unlike non-specialist nurses, were experienced in recognising the side-effects of phenothiazine drugs, and competent in the clinical assessment of psychiatric disorders. In some areas patients returned to the hospital or to an out-patient clinic for their injections; but (especially in rural areas) it was often more convenient and effective for a nurse to give the injection in the patient's home. Although this preparation is now available on prescription in the usual way, it is still widely considered among members of psychiatric services that it is advisable for the drugs to be administered, and their effects monitored, by qualified psychiatric nurses.*

The community psychiatric nursing service in Edinburgh was initiated before the depot phenothiazine drugs came into general use, but became concerned with them through the increasing numbers of patients for whom they were prescribed.

This study was not designed to consider the merits of different drug treatments or how they should be delivered to the patient. It is only relevant to say that the task of giving these injections appeared at the time of the study to form a substantial part of the work of the service, both in terms of the number of patients and of nurse-patient contacts. (53% of the patients of the service were receiving depot injections at the time of their 'key contact', and injections were given or offered at 49% of the total number of sample contacts). On the other hand, a large majority (86%) of nurse-patient contacts outside clinic sessions were not concerned with injections. Although the acceptance of responsibility for this task may have been a logical consequence of the service's concern for the after-care of chronically-handicapped patients, the administration of injections need not be considered either a necessary or a sufficient condition for the existence of the service.

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* In at least one rural area, community psychiatric nurses developed other aspects of their role, leaving injections to be given by the primary health care staff (MacDonald 1972).

13.3 The Community Psychiatric Nurse's Role within the Hospital

The results of the diary investigation showed that 57% of the nurses' working day was spent on the premises of the hospital. The distribution of the nurses' work both in time and place showed the extent to which it was centred upon the hospital - literally, as a location, and figuratively, in terms of patient care as practised in the hospital. The nurses frequently deplored the amount of time they were obliged to spend in attending clinical meetings or discussions in the wards and units to which they were attached.* They felt that these meetings kept them away from their proper field of work which ought to be in the provision of direct patient care outside the hospital. Moreover the matters discussed were often not relevant to their own work; and even when the subject-matter was relevant, their own perspectives and priorities were sufficiently different from those of ward-based staff to make it difficult for their point of view to be listened to or understood. Attendance at clinical team meetings was however necessary to give them the opportunity to influence clinical decisions and to receive referrals. It appeared to be through participation in the team meetings that the nurse acquired and retained standing as a competent and acceptable team member and colleague. This point was emphasized at interviews with the colleagues who referred cases to them: they said that they would probably not make use of the service unless they had direct contact with it and knew the individual members' capacities. Some teams nevertheless made little use of the nurse's services in spite of her attendance at meetings.

Clinical team meetings certainly seemed to serve a variety of ill-defined purposes, sometimes of interest to only a few of those present. Only one of the teams had a weekly meeting to discuss the 'community' side of their work. A more rational and less diffuse system of communicating with teams, giving priority to the management of patients in the community, would have saved the nurses' time, but might not have fulfilled the other function of establishing team membership.

The provision of adequate secretarial help with letters, messages, appointments and case-notes could have saved an appreciable

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* Cf. Rushing's remarks on the effort devoted by the occupants of poorly institutionalized roles to establishing their position in a psychiatric hospital (Rushing, 1964).

part of the time spent on office work, and might also have improved the communication of information about the nurses' work. A lay receptionist at the clinic could have relieved the nurses of clerical work there, but they did not think this would save time.

It seemed doubtful whether lack of time was really the limiting factor on the amount of nurse-patient contact. There are probably limits, in this often difficult and emotionally demanding field, to the amount of patient contact which can be tolerated; but it seemed unlikely that, at an average rate of 15 home visits per week, this limit had in most cases been reached. There was certainly no impression that the care of individual patients was being skimped because of other demands on the nurses' time. The limiting factors on the size of their case-load seemed to be more closely related to the range of possible sources from which they could receive referrals, and to their own preconceptions and those of others about their proper functions in relation to those of other disciplines, particularly social work.

The distribution of the nurses' work prompted the question whether it was right to consider that these nurses were primarily engaged in providing domiciliary psychiatric nursing care and treatment, or whether it would be more correct to consider them as occupying an intermediary role, maintaining communication between the hospital and its extra-mural patients, and extending the territory where hospital care could reach. Their lack of contact with the primary health care system, and their reliance on hospital resources for consultation and additional patient care, support the second interpretation of their role.

Deficiencies in communication about the nurses' patient care activities were noted by medical staff both inside and outside the hospital. This was unlikely to be improved without the provision of adequate secretarial services. Rationalization of the system of record-keeping, so that the nurses were not contributing to two sets of case-notes (their own and the hospital's) could have been helpful. The nurses' detailed case-notes, which were privately maintained in their own office, could have been of value if they had been more readily available to other clinical staff.

Establishment of some regular method of keeping general practitioners and community-based nurses in touch with the community

psychiatric nurses' activities would probably also have helped to maintain consistent treatment policies and to promote cooperation. This would have required some discussion of the extent to which hospital-based nurses should consider themselves accountable to patients' general practitioners. (It appeared that in general they only did so to a limited extent, in the context of physical illness).

A rationalization of scheduled meetings with the needs of extra-mural patients and staff in mind would make the nurses' work more open to scrutiny and supervision by members of clinical teams. This could have opened up opportunities for learning experiences for the nurses, and might have brought their perspectives and those of ward-based staff closer together.

The research worker became aware that problems arose for the community psychiatric nurses from divergent perspectives on the needs of patients and the functions of the community staff. The community nurses estimated needs for hospital care in terms of the patient's capacity to meet social demands and cope with daily living, and in terms of the amount of burden and distress he caused to others. Ward staffs - particularly the psychiatric and nursing staffs of acute admission wards - estimated need for hospital care in terms of the patient's capacity to 'benefit' from it, that is to say, to change his behaviour. If no change was likely to be achieved, then no need was seen for admission to or retention in hospital. Perspectives on the community nurse's functions also diverged: hospital staff often considered her only in the context of after-care, or as a mobile extension of the hospital; whereas the community nurses themselves considered that they had an independent preventive, caring and consultative role for patients who did not require hospital care.

13.4 Selection of Cases: Referral Criteria

The service had a clientele so closely associated with hospital care that it was clearly functioning mainly as an after-care agency, and as an adjunct rather than an alternative to hospital care. (Only 3% of the patients of the service had never attended at the parent hospital, at least for out-patient consultation. 58% of the patients had been in-patients during the year preceding their

key contact, and 77% of them were currently receiving some form of in-patient or out-patient care).

The functions of a community psychiatric nursing service will be largely defined by the characteristics of its clientele. It has been suggested by the present writer (Sladden 1974) that the case-load of a service, in respect of psychiatric history and current treatment, is likely to vary according to the location and organizational base of the service; these factors can thus be largely controlled by administrative decision. In this particular service, some general features of the clientele, such as the age-range, were decided in this way.

A more direct influence on the composition of the nurses' case-load was exerted by the referral policies of clinical teams. The nurses had a certain freedom to refuse to take cases or to weed them out of their case-load, but they did not take the initiative in finding cases independently. Therefore it is worth asking how far the salient characteristics of the clientele corresponded with the referral criteria expressed. It would be misleading to suggest that they might reflect an established consensus within the hospital about the role of the service, for the case-load had been gradually accumulated over a period of four years, and had been referred by (among others) the members of at least eight clinical teams. Moreover, opinions about referral criteria varied widely (see section 10). However a certain set of general expectations became evident in the course of interviews and informal discussions. According to these, the nurses would be asked to deal with schizophrenic patients after discharge from hospital, finding and supervising accommodation for them if necessary, or supporting and guiding their families in their management. The nurse would also administer or supervise medication.

The danger of exaggerating the influence of depot phenothiazine drugs on the nurses' case-load has already been discussed. The same applies to diagnostic category; all the major diagnostic groups were represented, although schizophrenics were in a majority.

The function of finding and supervising accommodation for people who could not live with their families dated from the early days of the service when its initial task had been to assist long-term patients to re-establish themselves in the community. This 'lodgings

officer' function was still of importance to the service itself and to the clinical teams. At the time of the study the community psychiatric nurses were also associated with a scheme of rehabilitation through progressive hostel environments, and with helping the graduates of this system to move on into the outside world.

Other criteria for nursing care were severely disturbed behaviour, and the existence of concomitant mental and physical disabilities. It is difficult to assess how great was the effect of these factors on the nurses' case-load. Isolation, loneliness and lack of social contact appeared to have prompted referral of some cases where such factors were thought to have helped to produce psychiatric illness. A sort of friendly social visiting of some of these cases was described in Section 9, which could perhaps equally well have been undertaken by a non-professional volunteer.

13.5 The Patients' Needs: Rehabilitation

Two features common to a high proportion of the nurses' clientele were a moderate degree of behaviour disturbance and chronic unemployment. Active rehabilitation programmes in hospitals aim to minimize work handicaps and other behavioural problems which attract social stigma or disadvantage. Early (1965) describes work as one of the two ladders towards resettlement in the community. Rehabilitative work is an important aspect of the skills of the psychiatric nurse in hospital; it was unexpected therefore to find conspicuously few activities reported by the community psychiatric nurses which could be described as rehabilitative. The prevalence of worklessness among their clientele did not seem to be recognized either as a fact or as a problem by the nurses, and neither they nor others saw a need for them to interest themselves in employment problems or to acquire skills in this area. Rehabilitative work was generally regarded as the province of other workers and agencies. The existing resettlement services mainly operate at the time of discharge from hospital. To quote Brown and his co-authors:

> "Rehabilitative efforts within the hospital must be continuously applied if hard-won progress is not to be lost, and the same seems to be true after the patient has been discharged. Unfortunately it is precisely at the point of discharge that rehabilitative efforts do tend to be relaxed". (Brown et al. 1966, p. 207).

Sheltered industrial organizations in some areas, and social workers in others, have ventured into this apparent gap in the conventional array of after-care services (Early 1965, Heimler 1967). Psychiatric nurses are outstandingly well equipped, from their hospital experience and training, to continue this aspect of rehabilitation with patients in the community, and it would enhance their effectiveness in tertiary prevention of chronic disability if they acquired a recognized role in this regard.

13.6 The Patients' Needs: Family Therapy

The clientele of this service demonstrated a combination of needs for clinical treatment and observation, and for social assistance and psychological support. It appeared that their

clinical needs were more adequately met; the degree of overt mental disturbance reported by nurses was generally not severe, whereas in a substantial proportion of cases a wide range of social, emotional and relationship problems were cited, affecting both patients and families.

The prevailing impression of the typical patient as socially isolated, lacking family ties, requiring benevolent support in a substitute home, proved to be accurate only for a fairly small proportion of the nurses' case-load. The majority of sample patients now lived in their own homes and more than half of the sample lived in some kind of family setting. In domiciliary practice, nurses were often in contact with the relatives of patients, both individually and in groups including the patient. At least one family member as well as the patient was present at one in every three home visits. At the same time, most home visits were conducted by one community psychiatric nurse without any other professional colleague present. Where relationship difficulties existed (and they were reported for more than half of the sample cases) the nurses inevitably became involved to some extent in the family interaction in so far as it affected the patients. The nurses showed that they were well able to identify and describe such situations, but the researcher gained the impression that they were often at a loss how to deal with them. It was these relationship problems within families that the nurses experienced as most problematical, and it was apparent that they evoked in the nurse feelings of anxiety, helplessness, anger, frustration, inadequacy and guilt. Various defences were mobilized against such feelings: denial of the existence of a problem - "That's just Willie !" - or of the possibility of making any impact on it - "They've always been like that, they'll never change!"; re-statement of the nurse's role specifically excluding such problems - "It's no good my upsetting the sister, Dr X deals with her, my job is to keep on getting into the house !" "Marital problems, that's social work !" Another tactic was to withdraw from the case - "We'll never get anywhere so long as he stays with that mother !" - but this was a last resort since, as will be noted below, nurses found it difficult to close cases. For whatever reason, the possibility of involving a social work colleague in such problems did not seem to be considered -

perhaps because this was not how nurses defined social work functions. A retreat into a purely task-centred role appeared to be a more acceptable solution.

The expectations of some psychiatrists, who were doubtful of the capacity of nurses to assume a psychotherapeutic role, or regarded them as a sort of second-rank therapist (see Section 10), probably gave implicit sanction for such withdrawals.

13.7 Objectives and Commitment in Nursing Care

The outstanding feature of the pattern of contact between nurse and patient was the durability and sheer persistence of the nurses' care. Planned withdrawal was relatively unusual; termination was often due to refusal on the patient's part. Even if the nurses gave up trying out of exhaustion and a feeling that their ministrations were having no effect, the decision was reversed as often as not as soon as some new crisis in the patient's fortunes was brought to their attention. This degree of commitment did not arise instantaneously on receipt of each referral; there was an initial process of sorting. In this study, approximately half of the newly-referred patients (having excluded those who were seen only once on an *ad hoc* footing) dropped out of the picture for various reasons. The other half were retained in the care of the community nursing service and there appeared to be no time-limit on the duration of the connection - the longer it continued, the longer it was likely to persist.

Persistence - staying-power - may be a characteristic of community psychiatric nursing services. Leopoldt (1974b) notes a "low rate of disposal" in a review of the case-load of two posts in Oxford, and suggests that this may be due to lack of discrimination between cases which require the continued intervention of specialist staff, and others which might be handed over to "a less skilled person such as a voluntary worker, neighbour or friend, or would a social worker be a more appropriate person?" Leopoldt does not go on to discuss criteria for making such distinctions, or means of finding and motivating alternative workers, but suggests that "necessity" for visiting (and by whom) should be regularly reviewed.

The members of the Edinburgh service held occasional reviews of their case-load in consultation with their unit nursing officer, at which both the frequency and the continuance of visiting were discussed. The question was posed in such a form as "Are we doing any good by continuing to visit?"

The objectives expressed by the nurses in regard to patient care tended to be open-ended and so vaguely expressed that it would be difficult to judge whether or not they had, at any point, been achieved (see Section 12). It was a point of pride, on which the nurses compared themselves favourably with other professional groups, that "their" patients did not "get lost"; in this they echoed views expressed by general practitioners and other community respondents, who suggestedthat the psychiatric services had a duty to maintain contact indefinitely with people who had once needed psychiatric care. If a crisis occurred involving a patient who had been dropped from their active list, the community psychiatric nurses appeared to feel that they had been guilty of an error of judgment, at least, if not negligence, and to expect blame from their colleagues. The extreme vagueness with which some of the latter phrased their referrals - "Keep an eye on Joe Bloggs" - could conceal expectations of unlimited and non-specific involvement which did not become explicit unless the nurse proposed to discontinue the case.

The result of these factors was a commitment on the part of the nurse, or of the team collectively, to the care of the patient for better or for worse. In many cases this posed little problem to the community psychiatric nurses. Some patients' behaviour, once established in a routine, remained remarkably predictable; through all vicissitudes the patient remained accessible to, and often dependent on, the nurses' care. Those who were less amenable to continuous care were patiently pursued through the changes and chances of their lives. Admission to hospital inevitably disrupted the pattern of contact in a substantial number of cases, but nurses usually expected to resume the connection when the patient was discharged.* In short, patients disappeared from and reappeared

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* The community psychiatric nurse's involvement did not however assure either continuity of care or consistency of treatment policy, because both of these depended upon which clinical team was responsible at any given time for the patient's care.

on the scene in the manner of a stage army, and the case-load of the service could be said to turn round rather than to turn over.

Leopoldt implied that unlimited commitment to a non-specific type of care is a wasteful use of the time of skilled nurses. Although this certainly seems probable, one should perhaps question his assumption that the level of skill required in a relationship is the only factor that need be considered. Some authorities (for instance Halmos 1965, Rogers 1967) suggest that there is an emotional component in treatment relationships that may be the true therapeutic factor, in which case a change of worker may be counter-productive. Others stress the nurse's use of previous acquaintance with the patient and experience of his previous patterns of behaviour. There is probably a case to be made in favour of unlimited non-specific commitment in cases where long-term problems of personality and relationships are prominent; logically in such cases the commitment should be on an individual rather than a team basis.

13.8 Training and Supervision

The nurses who participated in this study had undergone the conventional hospital-based training in psychiatric nursing; all were trained in the parent institution, however, which potentially could provide an unusually wide range of experience. In recent years nurse training at this hospital had included elements of the theory of group dynamics and some experience of therapeutic or 'community' groups in ward settings; however, there was little here, or in the content of the prescribed syllabus, that would prepare the nurse to act as single-handed therapist in individual or family group situations. It was unusual at this time and place even for qualified and experienced nurses to conduct group therapy sessions as sole or leading therapist. Experience of small family groups was available to nurses in two specialized units in the hospital; but none of the participant nurses had had experience of working in either unit. Orientation to community work for newcomers to the service was largely through observation of visiting staff in the field. No theoretical background material was given.

There was no systematic supervision of nurses' conduct of individual cases, and it was difficult to see from whom, in the existing structure, it could have been obtained. Some oversight was exercised by the unit nursing officer, but this was in an administrative, rather than a teaching context. Specific problems and difficulties in the conduct of particular cases could be raised with the consultant in charge of the case or with members of the clinical team; but there was no regular opportunity for the nurse to develop her skills and knowledge. Opportunities for gaining greater competence in handling interpersonal difficulties through supervised group and individual experience were not readily available and would have had to be sought by the nurse on her own initiative outside the hospital structure. The researcher's impression was that no need for additional skills or knowledge was seen, and that it was assumed that methods of psychiatric nursing learned in hospital could be applied with only minor modification in the community situation. It is fair to add that at the time of the study no approved course of training in community psychiatric nursing was in existence.

13.9 Interdisciplinary Relationships

The disciplines from which the community psychiatric nurse probably has most to learn in the area of relationships - whose work with individuals and families is comparable with her own in situation and content - are health visitors and social workers. The absence of collaboration with social workers was especially noticeable, considering that hospital-based social workers were members of the same clinical teams, and that they were relatively easily accessible compared with members of primary health care and community social work services. Cases were seldom referred between nurses and social workers. In the few cases in which a nurse worked alongside a social worker, the nurse defined her own function in strictly task-centred terms - "I just give him his Modecate". The nurses were also inclined to give task-centred definitions of social workers' functions, restricted to legal, financial and socio-economic problems, welfare rights and the like; the social worker's claim to distinctive skills in dealing with emotional

factors and social relationships was not acknowledged. It appeared that consideration of the real problem of overlapping functions was avoided by emphasising those divergent aspects of nursing and social work roles which could be most easily differentiated. Both nurses and social workers, however, were aware that their roles were to some extent interchangeable. There was a more explicit uneasiness among some social workers about the lack of definition which arose from undefined functional boundaries; they said that these issues should be discussed. Neither party felt much real inclination to do so, and the problem appeared to be dealt with as far as possible by mutual avoidance. The nurses however privately expressed feelings that difficult cases were 'dumped' on them when the social workers were tired of them and favourably compared their own staying-power. These feelings seemed to be related especially to the re-allocation of cases associated with the comings and goings of social work students.

The reluctance of the two groups to engage in direct discussion of their boundaries placed psychiatrists in the powerful but invidious position of choosing between the two services on a more or less arbitrary basis. Doctors rationalized their choices by defining the patient's problem as 'primarily clinical' or 'primarily social'. The process of reasoning here seemed to be essentially circular.

13.10 SUMMARY

In this section, the factors which influenced the work of the nurse were identified, and the findings of the study in this context are reviewed and interpreted.

Two major frames of reference - clinical and psycho-social - were found to be employed, and these were associated respectively one with work in an out-patient clinic, and the other with work in the domiciliary setting. The pervasiveness of the clinical concept and its association with depot phenothiazine treatment were acknowledged, but it was concluded that this model of care alone did not necessarily legitimize the role of a community psychiatric nursing service.

The service was found to be functioning as a mobile arm of the parent hospital, and to be engaged largely in after-care. It is suggested that the primary function of the nurse in this setting was to act as an intermediary between the hospital and the patient, rather than to give direct nursing care. This was at variance with the nurses' own concept of their role. Criteria for the referral of patients varied widely, but the major task was the after-care of schizophrenic patients either in residential or family settings.

Contact with primary health care workers and with social workers in relation to patient care was limited; the nurses relied very largely upon hospital resources. Role relationships with social workers were problematical.

The care given was notable for patience and persistence. The techniques used, in interpersonal terms, were conservative and non-dynamic. The needs of the patients in respect of clinical care were well fulfilled, but some social needs and problems (employment problems, behavioural disturbances and relationship problems within families) seemed to require additional attention.

Supervision of nursing practice was episodic and not directed to developing nurses' skills. No special training or background knowledge was offered or apparently considered necessary. In the writer's view, however, extended skills were needed especially in handling disturbed family relationships.

SECTION 14: SOME REFLECTIONS ON THE FINDINGS

Evidence on the functioning of a community psychiatric nursing service in a particular setting has been presented and discussed. It has already been emphasised that a study of this kind provides no basis for drawing generalized conclusions or for prescribing principles to be more widely applied. It may be apposite however to offer some reflections on the findings, inspired by the researcher's reading of the literature and by her observations and impressions during the course of the study.

The situation of the community psychiatric nurse as observed during the study showed a number of ambiguous and incongruous features, and was characterised by the lack of a fully legitimate role in the community setting. It is probably impossible and may not even be desirable to define too closely the roles of workers in a complex situation. But ambiguity entails doubt and doubt inhibits action. Some of the more obvious sources of ambiguity could be clarified without imprisoning workers in a prescriptive strait-jacket.

Ambiguity was noted in the nurses' own conceptions of the objectives of their service; for instance, regarding the balance to be struck between clinical treatments and interpersonal relationships in patient care, or between the allocation of time between direct patient care and liaison functions. There were anomalies in the expectations of colleagues: an example was the question of communicating with general practitioners. In theory psychiatrists in the hospital hoped that the community psychiatric nursing service would improve communication with GPs, but in practice some of them were uneasy if the nurses communicated directly with GPs (section 10), either because this by-passed the expected channels of communication, or because they feared that the direction of treatment might become confused. Similarly GPs expressed wishes to be consulted and informed, but when this was done, they might (as one did - see section 11) construe the nurse's action as interference. Domiciliary treatment is, in principle, the responsibility of the family doctor, and in that context the consultant's role is to do what his title implies. But, as hospital employees, the nurses felt themselves responsible to

consultant psychiatrists; and, in so far as they were providing an extension of hospital care, it was reasonable for them to do so. To whom then is the community psychiatric nurse responsible for her clinical work? To whom should she be answerable for the psychosocial aspects of her work - for the conduct of nurse patient relationships and for the effects of her interaction with patients and families? Should the nurse, or the service collectively, assume autonomous responsibility for her work?

In practice the nurses worked in a situation of some isolation and were often obliged to take important decisions on their own responsibility. How far was their de facto autonomy at variance with de jure ancillary status?

The major source of ambiguities and inconsistencies appeared to arise from a failure to relate the service and its objectives to a consistent model of what community care should mean in the context of psychiatry. Mention was made earlier in this report (pp 17-19) of three different interpretations which are attached to the concept of community care, implying distinct and incompatible expectations of the roles which nurses should perform. External pressures to conform with one or other of these were brought to bear from time to time on the nurses, who themselves appeared to subscribe to one model in one context and to another in a different context.

The first model of community care, in which provision for medical/psychiatric and for social needs are conceptually distinct and statutorily and administratively separate, assumes that these aspects of need are distinguishable in practice and can be catered for by separate services. In this, the officially endorsed model, 'health care' workers (including nurses) will confine themselves to 'clinical' functions with patients who can readily be defined as 'sick', leaving 'social' needs to be looked after by 'social' agencies. The provision of any form of social care by health services outside hospital premises is regarded as unwarrantable, although it is accepted that many of the social and environmental needs of patients in hospital are catered for by the health service. In this model the functions of community services are defined according to the assumed skills of the workers. It lends itself readily

to task-oriented concepts of care.

This model did not seem to fit the situation as observed. In the first place it seemed scarcely practicable to separate psychiatric from social needs in a group of people in whom psychiatric disorder and social dysfunction are virtually synonymous. Secondly the model disregards an intermediate area of difficulty which could be designated psycho-social and which manifests itself in both psychiatric and social problems. Thirdly the model assumes concurrent provision of both psychiatric and social care; but according to the evidence the provision of 'social' care was haphazard and the liaison between health and social care professionals sadly inadequate. Nevertheless this model appeared to be assumed by some informants and was applied sporadically by the community psychiatric nurses in the context of their clinic practice and of cases in which social difficulties were prominent.

The second model proposes an alternative to institutional care. In this model the functions of services are defined by the location of clients. The distinction between 'social' and 'medical' care takes second place to that between institutional and community care. In this context 'integrated' medical/psychiatric facilities are considered as part of community care, while psychiatric hospitals are not. In this model the nurse is expected to meet the total needs of her patients, as she would in hospital, at all stages of illness and recovery. She may also have an intermediary function in relation to 'community' facilities.

This model cannot realistically be applied to the Edinburgh service as it was actually observed in operation; but some of the ideals proposed - avoidance of hospitalization, treating the patient in his social context - were subscribed to in theory. The community psychiatric nurse was more a facilitator of hospital care than a substitute for it.

The third theoretical model of community care is that of a comprehensive psychiatric service providing a range of readily accessible and flexible services (including psychiatric hospital facilities) adapted to the needs of its clientele. This model is linked with concepts of social psychiatry, embracing attempts at primary prevention and intervention in psychiatric crises to

correct underlying social and interpersonal difficulties. The roles of professionals in this model are to be defined in terms of the needs of the client, and should be sufficiently flexible to accommodate changes over time. Continuity of care is emphasised, as is free movement by the patient from one phase or environment of treatment to another. This model also implies considerable freedom of movement for professionals and requires open communication at all stages of care and treatment.

Many of the aspirations of the community psychiatric nurses and of their colleagues were towards this ideal model, but the degree of continuity, flexibility, integration of treatment policies, and free communication which were actually achieved, fell short of the ideal. The service had extended the territory of hospital treatment, and had made a worthwhile beginning of a domiciliary psychiatric nursing service although it was largely restricted to ex-hospital patients. In a comprehensive service, psychiatric nursing care would be available in all settings and to all patients who needed it, irrespective of their past psychiatric history.

The needs of patients as identified in this study were for a combination of psychiatric, social and psycho-social care. An extensive literature exists about social factors and social concomitants in mental disorder, which shows that long-term psychiatric handicaps, particularly those designated as "schizophrenic", are characterized by multiple difficulties in making and maintaining satisfactory personal relationships and in meeting the demands of a normal position in society. The prevalence of such difficulties among the clientele of this service was amply confirmed by the nurses' observations.

What guiding principle should be adopted in deciding the roles of staff and the distribution of functions in psychiatric services? The advantage of a comprehensive service including hospital and 'community' facilities, is that it could be adapted in a flexible way to the needs of patients and could avoid rites de passage and legal and administrative barriers between one phase of treatment and another. The adoption of such a principle might entail a fresh look at historical lines of demarcation between existing professional groups.

What part should psychiatric nurses play in such a service? The nurse in the psychiatric hospital has a well-recognized role which includes medical-auxiliary functions, the creation and regulation of an environment in which therapy can take place, and the assumption of a therapeutic role through individual relationships and group interaction with patients. In contrast, the work of the psychiatric nurse in the community lacks legitimacy - in the sense of conforming to established standards of practice - except in so far as the medical-ancillary aspects of her role are concerned. This is partly because psychiatric nurses have not acquired recognition of skills or effectiveness in the psycho-social and social aspects of care, and partly because it is assumed by many that in making such claims she is trespassing across established professional boundaries upon the territory of another discipline, that of social work. This is a doubtful proposition for two reasons. Firstly it seems probable that nursing skills were extensively drawn upon in the practice of mental health social workers (while such existed). Secondly the argument for exclusive legally sanctioned domains of professional practice rests upon the need to protect the public from untrained practitioners and on the guardianship of particular areas of specialized knowledge. Interpersonal skills however are acquired in practice and do not rest on a particular corpus of knowledge; furthermore social workers cannot claim that theirs is the only discipline which practises these skills. Relationship skills are unquestionably <u>prescribed</u> for the psychiatric hospital nurse, however strong the evidence may be that such skills are at present not taught and very unevenly demonstrated.

If the proper role of the psychiatric nurse in domiciliary practice is considered in the context of the patient and his needs, it is difficult to see how she can confine herself to a purely 'clinical' role. So long as the nurse deals with her patients only in the hospital environment, it is possible for her to deal with behavioural and relationship problems in that setting, while she can leave it to others to intervene in home and family difficulties; but once she enters patients' homes to care for them there, the nurse inevitably and necessarily becomes involved in the interaction of patients and families, not only as an observer but also as a participant, in as much as these relationships affect patients.

The problem posed for the nurse by these situations is how far she should try to restrict her intervention within the limits suggested by her previous training and experience. Whether the effect of her involvement is haphazard, or is used constructively to some purpose, depends on the nurse's ability to analyse the situation, her insight into the effect of her own personality and her skill in modes of intervention. There is little however in current systems of nurse training that prepares her to intervene in a constructive way.

The authors of a survey of recent evidence (Fraser and Cormack, 1975) concluded that "Nurse training, in general, offers little in the way of developing the nurse's therapeutic potential. Rather, it is seen to reinforce the prevailing medical model of mental disorder and to perpetuate the delimitation of the nurse's role to that of medical aide".

The therapeutic importance of nurse-patient relationships is emphasised throughout the nursing literature, and has been ritually endorsed in innumerable official reports and policy documents. The current syllabus of training for registered psychiatric nurses (General Nursing Council for Scotland, 1973) includes a mention of the topic, but gives no further guidance on how, or whether, skill in this area can be taught. Altschul notes, in her study of nurse-patient interaction, that nurses could give no theoretical basis for their interactions with patients, and that "the skill employed by nurses in the use of relationships remains to be identified and described" (Altschul 1972 p. 190). Since interactional skills were generally believed by nurses to be essentially intuitive and spontaneous (p.189), it was considered scarcely possible to develop them by teaching methods. This pessimistic view is not, however, accepted by other disciplines. In social work, for instance, training programmes are largely based on the assumption that understanding, insight and skill in the conduct of relationships can be developed in students of varied personalities. A variety of means are used including background knowledge of relevant theories; observation of other workers and discussion of their methods; practical work under supervision with group discussion as well as individual counselling; and lastly critical appraisal by members of the same and other disciplines.

The observation of disturbed family relationships does not necessarily mean that these are amenable to treatment. Nevertheless it is clear that in a substantial proportion of cases both a need and an opportunity exists. If the concept of separating health and social care is adopted, and if the nurse has to limit herself to a clinical role, it follows that her work should often be associated with that of a suitably skilled family therapist. In the context of a comprehensive service, it is likely that a generic role will be assigned to the nurse and that she will acquire a legitimate therapeutic and preventive function in dealing with the relationship problems and social difficulties of her patients. Her needs for adequate initial training in this context have apparently already been acknowledged;* but further needs for continued supervision and professional support in dealing with family problems should be recognized and supplied. Nurses should profit from the experience of other related disciplines (especially health visiting and social work) in the development of interactional skills, and until a frame of reference specific to psychiatric nursing is developed, they must draw on relevant concepts employed in related fields.

In developing skills and techniques appropriate to the community situation, psychiatric nurses have much to learn from the other domiciliary workers whose roles overlap their own. These are health visitors, community nurses and social workers. The literature suggests that conflict is likely to arise where there are degrees of overlap between occupations. It appeared in this study that the lack of collaborative work with social workers, and the virtual absence of contact with community nurses, could be interpreted as a tactic for avoiding potential conflict. The absence (or avoidance) of contact also prevented the discussion of roles and resolution of potential conflict in constructive ways. There is no reason why the roles of psychiatric nurses and of social workers should not be differentiated in terms of their particular areas of expertise,ø recognizing that there

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* Joint Board of Clinical Nursing Studies 1974.

ø Examples of nursing functions are the recognition and assessment of specific psychiatric and organic conditions, and skill in the use of medication; social workers have statutory functions in the care and protection of children and old persons, and their work in connection with the courts and with non-psychiatric types of deviance.

remains an important area of skill in the management of relationships which is, or should be, shared by most of the 'helping professions'.

There is a danger that by avoiding mutual encroachment, social workers and nurses may leave untilled a vast and potentially fertile tract of territory - that is to say, assisting with the problems of chronically disturbed psychiatric patients and their families. There are indications in this study that this field may be being neglected; studies directly focussed on the day-to-day problems of patients in the community would be necessary to investigate the point fully.

Three points follow from the considerations discussed above:

The first is that a nursing service does not function in isolation from the other parts of the service. If it is desired that it should contribute to a comprehensive psychiatric service, the necessary reordering of the whole structure must be planned alongside it.

The second is that psychiatric nurses, like other professionals, require constructive support and critical appraisal from members of their own specialism, both nurses and others. In a structure in which they find themselves working in isolation, the standard of service is bound to suffer. On the other hand reports in the literature, like this study, suggest that primary health care staff are likely to make referrals only to colleagues with whom they have personal contact. Therefore a comprehensive service giving psychiatric nursing care of high quality to people in the community requires to have substantial links both with specialist and with generalist services. This will not be easy to achieve but one attempt at least has already been reported (Leopoldt 1975a).

The third point is that the manner in which a service functions and the population which it serves are largely determined by its position in the health service structure and its relationships with other services. These should be related to the model of community psychiatric care which it is desired to carry out and the objectives which it is hoped to achieve. The conclusion of this study seems to be that fundamental concepts and objectives should be fully discussed and agreed with all concerned before the structure of the service is decided.

ANNEX 2.

Membership of Steering Committee

DR. J.W. AFFLECK	(Physician Superintendent, Royal Edinburgh Hospital; Honorary Lecturer, Department of Psychiatry) (Chairman).
MR. A. ADAMS	(Scottish Home and Health Department, Social Work Services Group).
DR. J.T. BOYD	(Scottish Home and Health Department, Research and Intelligence Unit).
MISS D. BUGLASS	(Sociologist, MRC Unit for the Epidemiology of Psychiatric Illness).
PROFESSOR G.M. CARSTAIRS	(Department of Psychiatry).
MISS E. HILL	(Nursing Officer, Scottish Home and Health Department)
MR. A. NICKERSON	(Senior Nursing Officer, Royal Edinburgh Hospital)
MISS R. SCHROCK	(Lecturer, Department of Nursing Studies
MR. JOHN G. SUTHERLAND	(Chief Nursing Officer, Royal Edinburgh Hospital).

ANNEX 4

DESIGN AND METHODS

LIST OF ANNEXES

ANNEX 4/1.

GLOSSARY OF TERMS USED

ACTIVITY SCHEDULE — The second and more detailed schedule used in the study of nurse/client contacts. The schedule contains pre-defined descriptions of aspects of the content and process of contacts. (See Annex 4/3.2)

CLIENT — Term used to denote both patient of the community psychiatric nursing service and member of the patient's immediate family or household.

CONTACT (NURSE-CLIENT CONTACT, NURSE-PATIENT CONTACT) — Occasion when a community psychiatric nurse had personal contact with a client (q.v.). Contact might be face-to-face or by telephone, and implied some form of effective communication. (See also Key contact)

CONTACT RECORD (CONTACT SLIP) — First schedule giving information about nurse-client contacts and their circumstances. (See Annex 4/3.1)

DAY-PATIENT — A person residing at home but attending on one or more days per week at the parent hospital for several hours' stay, during which treatment, care and industrial or occupational therapy might be provided.

DEPOT PHENOTHIAZINE DRUG — A drug of the phenothiazine group of major tranquillizers, administered by intra-muscular injection and effective during a period of approximately two to four weeks.

FAMILY (FAMILY MEMBER) — Persons living in the same household as a patient as part of a family group.

FOLLOW-UP PERIOD — The final two months of the study period (i.e. 1 January 1973 to 28th February 1973) (During this period nurses continued recording of contacts with patients and families in order to produce information on frequency of contact for all cases in the sample.)

IDENTIFIED PATIENT — Person receiving care, treatment or consultation from the psychiatric services of the parent hospital and recorded in the hospital's records as a patient.

IN-PATIENT — Person currently occupying a bed and receiving full-time treatment at the parent hospital.

KEY CONTACT — Initial occasion when nurse-patient contact was recorded in any particular case - i.e. the contact from which the inclusion of a case in the study series began.

MODECATE — A depot drug of the phenothiazine group (Proprietary name).

OUT-PATIENT — A person residing at home and attending at intervals at psychiatric clinics of the parent hospital. The definition includes patients who attended the weekly injection clinic conducted at the hospital by the community psychiatric nursing service.

PARENT HOSPITAL — The Royal Edinburgh Hospital.

PARTICIPANT, PARTICIPATING NURSE — One of the five nurses forming the field staff of the community psychiatric nursing service at the time of this study, whose work provided the material for the study.

PATIENT — Person referred to the community psychiatric nursing service and accepted for a service of any kind. See also Identified patient

SAMPLE (STUDY SAMPLE) — A sample comprising 50% of the case-load of the community psychiatric nursing service during the sampling period. (The sample was drawn by a systematic method (i.e. alternate cases) from a list of all cases with which the service had contact during the sampling period).

SAMPLING PERIOD — The first four months of the study period (i.e. 1 September 1972 to 31 December 1972). The time during which the case-load of the community nursing service was identified from the nurses' contact records.

STUDY PERIOD — Six months from 1 September 1972 to 28 February 1973 during which main study of nurse-client contacts took place.

ANNEX 4/2.1

ROYAL EDINBURGH HOSPITAL.

STUDY OF PSYCHIATRIC COMMUNITY NURSING.

CODES FOR USE WITH DIARY SHEETS.

LOCATION (your own, during activity)

1 - 8 Areas 1 - 8 (see map). SPECIFY either code no. or name of street or district.

9 Royal Edinburgh Hospital premises

0 Any other location. SPECIFY, please.

ACTIVITIES

01 Visit/interview (with client/client's family) - routine.

02 " " " " " " - non-routine (e.g. suspected crisis, impulse visit, chance encounter).

03 " " " " " " - related to emergency admission or compulsory detention.

04 Abortive visit.

05 Clinic.

06 Discussions with colleagues, other agency staff, landladies, etc., directly concerned with individual client/client's family.

07 Finding accommodation, visiting lodgings and hostels, telephone contacts with staff, etc.

08 Attendance at social clubs, voluntary organisations.

09 Ward meetings, psychiatric team meetings/case conferences.

10 Other meetings, policy discussions, Unit meetings, conferences, training sessions.

11 Reading and writing case-notes, other office work, personal contacts connected with administrative matters.

12 Research activities.

13 Travelling and time expended on car (except providing transport for others)

14 Providing transport (FOR WHOM? Please SPECIFY in Remarks column)

15 Meal-times, relaxing, personal.

16 Wasted/can't remember.

DO NOT RECORD LOCATION.

17 Other (please SPECIFY in Remarks column)

ANNEX 4/2.2

ROYAL EDINBURGH HOSPITAL.

STUDY OF PSYCHIATRIC COMMUNITY NURSING.

DIARY SHEET.

NURSE'S CODE [ ] DATE [ ] SHEET NO. [ ]

TIME			ACTIVITY	LOCATION	REMARKS
Start	End				

ANNEX 4/3.1: 'CONTACT RECORD'

ROYAL EDINBURGH HOSPITAL

Study of Psychiatric Community Nursing

(SS.14/8/72 Rev.)

PLEASE COMPLETE A SLIP for every contact with a client and/or his family/household.

Community Nurse's Code(s) ☐☐/☐ Date _____

Client's name _____

Persons present at visit/interview

(TICK, and SPECIFY by relationship with client or professional role)

Client ..... ☐

Family member(s) ..... ☐

_____

_____

_____

_____

Other(s) (please include other professionals).. ☐

_____

_____

_____

Locality of contact (TICK)

Client's home/residence ..... ☐

Medecate clinic ..... ☐

Royal Edinburgh Hosp.(other then clinic)... ☐

Other (please SPECIFY)..... ☐

_____

_____

Initiator of contact

Who proposed or prompted this particular contact?

Yourself ..... ☐

Client/client's family member ..... ☐

Ward nurse ..... ☐

Psychiatrist ..... ☐

Other (please SPECIFY) ..... ☐

_____

_____

Has there been any marked CHANGE in the client's condition or circumstances or any special CAUSE OF STRESS?

If so, please NOTE BRIEFLY.

_____

_____

_____

_____

_____

Please turn to next sheet

OBSERVATION/ASSESSMENT

On this occasion did you pay SPECIAL ATTENTION to any of the following?

Client's treatment situation (e.g. what drugs prescribed? Is he taking them?) ... ☐

Client's response to medication or treatment (e.g. effectiveness of drug(s), side-effects?) ..... ☐

Physical health, physical condition ..... ☐

Mental state ..... ☐

Behaviour ..... ☐

Material/environmental/social circumstances ..... ☐

Relationships/interaction in family (or similar group) ..... ☐

Other (SPECIFY) ..... ☐

PROCEDURES

On this occasion what methods or approaches did you try to use in talking to the client and/or his family?
(TICK the appropriate phrase(s) below; or, if none apply, please describe your method in your own words.)

Did you:

Express sympathetic interest, reassurance, confidence or encouragement? ..... ☐

Use systematic questioning to elicit specific information? ..... ☐

Hold a friendly conversation on normal social topics only? ..... ☐

Advise, criticise, persuade or warn? ..... ☐

Allow or encourage ventilation or release of feelings? ..... ☐

Give information, explanation or instruction? ..... ☐

Encourage the client to think carefully about the nature or effects of his current situation and behaviour ? .... ☐

Listen and respond to disturbed or delusional talk? ..... ☐

Interpret to the client the origin or dynamics of his/her patterns of response and behaviour ? ..... ☐

Use an authoritative or directive manner? ..... ☐

Offer practical assistance or referral to another agency? ..... ☐

Other (please SPECIFY) ..... ☐

_____

_____

_____

_____

TOPICS

What were the MAIN topics discussed?
(please TICK those which apply and SPECIFY any <u>important</u> matters not included on the list.)

- Physical health, symptoms or signs ☐
- Mental state, symptoms or signs ☐
- Personal appearance ☐
- Behaviour problems and their management ☐
- Medical/psychiatric treatment ☐
- Attitude to hospital(s) ☐
- Dependence on drugs including alcohol, excessive smoking ☐
- Activities/hobbies/social life ☐
- Social isolation, loneliness ☐
- Work, employment ☐
- Care of children ☐
- Housing ☐
- Financial matters, budgeting ☐
- Legal matters ☐
- Health and Social Welfare services and how to obtain them ☐
- Sexual problems ☐
- Marital problems ☐
- Family relationships ☐
- Other interpersonal relationships ☐
- Other (please SPECIFY) ..... ☐

_____

ANNEX 4/3.2

'ACTIVITY SCHEDULE'

ACTIVITIES AT VISIT/INTERVIEW

On this occasion did you do any of the following? (TICK those which apply and SPECIFY any important activities not described)

Personal service (includes "basic nursing" and small tasks done for client, e.g shopping)

- Wash, bath, shave client, wash/dress hair, change clothes ..... ☐
- Prepare or serve food or drink ..... ☐
- Provide transport ..... ☐
- Other (SPECIFY) ..... ☐

_____

Technical nursing

- Give injection ..... ☐
- Administer drug(s) by other route ..... ☐
- Any other technical nursing procedure (e.g. apply dressing) ..... ☐

(SPECIFY)

_____

Activities undertaken jointly with client (aimed at improving rapport or providing occupation, diversion, training or rehabilitation)

- Personal grooming, care of clothes ..... ☐
- Social activities (e.g. offering and receiving hospitality) ..... ☐
- Domestic tasks in house or garden ..... ☐
- Using public facilities and services (e.g. buses, telephone, shops, library etc.).. ☐
- Recreational or educational activities (e.g. clubs, sports, concerts, lectures etc.) ☐
- Other (SPECIFY) ..... ☐

_____

Regulation and guidance of client's behaviour

- Tracing client's whereabouts ..... ☐
- Escorting client/patient to hospital or elsewhere ..... ☐
- Using physical restraint to control client's behaviour ..... ☐

Other activities (please SPECIFY)

_____

_____

ANNEX 4/3.3

NOTES FOR USERS OF CONTACT SLIPS

1. PURPOSE OF SLIPS These forms are designed to provide a record of your activity, throughout the period of the study, in relation to every individual client and family or household to whom you give service. They are the primary source of information in the study. Data will only be compiled about clients who are named on one of these slips - and information about the team's activity (for instance frequency of visiting, and many other factors) will be derived from them. The accuracy and completeness of the picture which the study produces will therefore depend almost entirely on the use made of these slips.

2. COMPLETION OF SLIPS I would suggest that, whever possible, slips should be completed directly after each contact or at any rate as soon as possible. This is likely to be quicker and easier in the long run, and to give a more accurate picture than if a number of slips are completed e.g. at the end of the day.

3. A CONTACT means any occasion on which you see or talk to a client or visit his family or household in connection with his case. Telephone contacts may be included unless they are only incidental to other personal contacts. In this case would you please note under Location - other that the contact was by telephone?

4. A CLIENT is any person who has been referred - or has referred himself - to the team and been accepted for a service of any kind, whether or not he becomes a regular member of your case-load. Normally the client referred to you will be a person with whom your clinical team has been actively involved, but this may not be so on all occasions.
   Please give the client's forename if you can, to aid identification. Please include services of brief duration or once-for-all incidents (such as advising a hospital patient about accommodation, or escorting an 'emergency' patient to hospital).

5. NURSE'S CODE Only one slip need be completed for any one contact even if more than one community nurse was present. Please would the nurse reporting the contact enter his/her code number in the first box, and the code or name of the other team members present in the appropriate place?

6. PERSONS PRESENT AT INTERVIEW Please identify people by their relationship with the client rather than by name - for instance, daughter-in-law, neighbour, wife's lover, policeman, etc. Under Others please include any people working in the health or social welfare field whom you encounter, whether the meeting was planned or by chance.

7. INITIATOR OF CONTACT This means the person whose initiative 'triggered off' this particular contact - for instance the doctor who calls you in to investigate a strange letter, the nurse who notices an ex-patient behaving oddly in the street, the client who turns up at the door, or yourself planning your day's work.

8. MARKED CHANGE OR SPECIAL STRESS Could you make a note in this space if you notice a distinct change in the client's condition or behaviour; or if you are aware of any change of circumstances which is likely to affect him - e.g. change of medication, moving house, physical illness, loss of job, a disappointment or bereavement, etc.?

ACTIVITIES, OBSERVATION, PROCEDURES AND TOPICS

9. In general, most of these may relate either to the patient himself or to his close relative etc. whom you are visiting.

10. The distinction between 'Activities', Observation and 'Procedures' is somewhat arbitrary. It reflects the difficulty of wholly disentangling what you do from how you do it. In general 'Activities' relate to a context of physical, practical action, 'Observation' to an interior process of registering perceptions and drawing conclusions from them, and 'Procedures' to the interactional context.

11. At any contact the nurse is likely to listen and talk; to attempt to build up a personal relationship; and to observe and assess the situation. These features are assumed to be present; you are only asked to record specific aspects of them.

ACTIVITIES

12. 'Personal service' and 'Activities undertaken jointly' are closely related and may overlap. The intention is that the first should describe things that you definitely do for the client, while the second denotes activities in which he is an active participant. If in doubt, please specify on the form or discuss with me.

OBSERVATION/ASSESSMENT

13. Every nurse no doubt takes note routinely of the situation in each one of these areas whenever he/she visits a client. It is intended that you should only indicate those areas of observation which are of particular concern or importance to you on the occasion recorded.

14. The 'client's treatment situation' is meant to cover, for instance whether he has consulted his GP and with what result; whether he has out-patient appointments and attends for them; whether he is keeping to his treatment regime. 'Response to

medication/treatment' specifically concernes the effects of treatment as observed by or reported to you.

15. 'Mental state' is meant to include emotional states and attitudes as well as the presence or absence of more specific psychiatric signs and symptoms.

PROCEDURES

16. This does not pretend to be an all-inclusive list of 'helping procedures' - but I believe it includes a number of the more frequent modes of approach to the client. In cases where using this framework would misrepresent the situation as you saw it, I hope you will give your own brief description of your method.

17. The items are not mutually exclusive. More than one of the 'procedures' may often be in use at the same time. In such cases please tick all those which apply.

18. In some cases the same mode of approach may be expressed by verbal or non-verbal means - for instance a hug may be the equivalent of many consoling words. The descriptions may be interpreted where necessary as applying to non-verbal forms of communication.

19. Some notes are attached to illustrate how the section on 'Procedures' may be applied. Examples are given of situations which the various descriptions might fit; most of them are drawn from the accounts of visits to clients which members of the team wrote at my request.

TOPICS

20. Please include only those which were prominent in the conversation on this occasion, either because they occupied a substantial proportion of the interview, or because you consider them important in this context.

'Attitude to hospital' has caused difficulty; I mean it to cover discussions about clients' or families' feelings about admission

or discharge; attitudes to individuals or groups of hospital staff; previous experiences in hospital etc. 'Medical/ psychiatric treatment' covers discussions of specific forms of treatment, their indications and their effectiveness.

EXAMPLES OF APPLICATION OF PROCEDURES ITEMS

EXPRESS SYMPATHETIC INTEREST, REASSURANCE, CONFIDENCE OR ENCOURAGEMENT

This covers the ways in which the nurse may express warmth and concern for the client; show understanding and a wish to help; convey reassurance on matters about which the client feels anxious or guilty; or support his self-image in ways which may improve his ability to function.

EXAMPLES "..... manner of friendly interest and real concern ..." "Empathy with wife ...." "Admired patient's dress and appearance in order to encourage her to keep it up ..."

USE SYSTEMATIC QUESTIONING TO ELICIT SPECIFIC INFORMATION

EXAMPLES "Firm handling was required to elicit sufficient material ...." "Tried to direct conversation towards patient's social life in order to find out ....."

HOLD A FRIENDLY CONVERSATION ON NORMAL SOCIAL TOPICS ONLY

It is assumed that this will form part of almost every contact, and there is no need to indicate it unless this was the only method you used. Often it may be a way of indirectly, expressing concern etc. (see 'Sympathetic interest' above). If you have difficulty in deciding between the two items, you could consider how far you were aware of a definite need for sympathy, reassurance etc. on this occasion and consciously set out to meet it.

EXAMPLE " Visited ..... to give a short period of friendly interest and conversation ...."

ADVISE, CRITICISE, PERSUADE OR WARN

The nurse may attempt, by means of direct expression of her own opinions and attitudes, to exert a direct influence on the client's

behaviour, ranging in force from mild suggestions to emphatic warnings.

EXAMPLES "Gentle criticism of personal appearance ..." "Advised her to walk more".

ALLOW OR ENCOURAGE VENTILATION OR RELEASE OF FEELINGS

This refers to exploratory methods which encourage the client to express pent-up feelings and emotionally-charged memories - to "let off steam" in a manner which promotes release of tension. Thus it implies more than just listening to a compulsive talker (if in such a case no specific relief is obtained by the client). At the same time, the nurse may often introduce methods of reassurance to reduce anxiety and guilt accompanying the material verbalised, or may encourage the client to discuss it rationally.

EXAMPLE "Talked about patient's father's recent death and how the patient felt about it."

GIVE INFORMATION, EXPLANATION OR INSTRUCTION

Direct attempts by the nurse to convey knowledge or understanding - the exercise of a teaching function.

EXAMPLE "Explained how to form a work pattern."

ENCOURAGE THE CLIENT TO THINK CAREFULLY ABOUT THE NATURE OR EFFECTS OF HIS CURRENT SITUATION OR BEHAVIOUR

This covers reflective or logical discussion intended to promote the client's awareness or understanding in any of the following areas:-

The client's external situation - economic, social, physical, educational etc. - and the nature of the people with whom he is associated.

The actual or probable effects of the client's actions on others or on himself; alternative courses of action open to him; his use of available resources; his relation to 'significant others'.

Feelings, attitudes and beliefs involved in the current situation which the client has not hitherto realized or verbalized; inappropriate or problematic reactions; the reality of his own situation or other people's behaviour when his perception of them seems to be distorted.

EXAMPLES "I commented on her great anger". "Discussed difficulty in finding work and how his unkempt appearance might contribute to this." "Demurred at .... statements concerning activities of home help which she could not have known about ...."

LISTEN AND RESPOND TO DISTURBED OR DELUSIONAL TALK

EXAMPLE "Talked about delusional and hallucinatory experiences".

INTERPRET TO THE CLIENT THE ORIGIN OR DYNAMICS OF HIS/HER PATTERNS OF RESPONSE AND BEHAVIOUR

This concerns methods intended to help the client develop awareness and understanding of intra-physic forces or psychological patterns which determine how he responds and acts. The area of consideration may be dynamic (how these forces operate) or historical (how they developed).

EXAMPLES could, for instance, concern defence mechanisms used by the client; "Perhaps you really feel the same way about her as you say she feels about you ...." "That sounds a good enough reason but I wonder if you are using it to avoid looking at your real motives."

USE AN AUTHORITATIVE OR DIRECTIVE MANNER

Any situation in which the nurse uses personal authority as a parental figure in a client's eyes, professional authority derived from his/her special skill, or institutional authority arising from her links with the hospital and health care system.

EXAMPLES "Spoke in a kind but firm 'big brotherly' manner ...." "Pep talk to husband ..." "Pointed out her duty ..."

OFFER PRACTICAL ASSISTANCE OR REFERRAL TO ANOTHER AGENCY

The offer should be recorded whether or not it was accepted.

EXAMPLES "Offered help of CSV ..." "Suggested an appointment with psychiatrist ..." "Offered cast-off clothing."

ANNEX 4/4.1

Case-Record Section A: extracts from case notes

Personal information

1. Patient's name .....
2. Patient's index number .....
3. Date of key contact (initial contact during study) ...
4. Sex .....
5. Date of birth .....
6. Age group (at date of key contact)
   15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+, NK
7. Civil status (at date of key contact)

   Never married
   Married
   Separated (legal separation)
   Widowed
   Divorced
   NK
8. Marital situation (at date of key contact)

   Single
   Living with spouse
   Living in 'irregular' union
   Other SPECIFY
   NK
9. Patient's occupation .....

   (If retired, normal occupation before retirement. State if patient never employed).
10. Husband's occupation .....

    (in case of married/widowed/divorced woman)
11. Father or guardian's occupation .....

    (at time of patient's birth if known)
12. Social class (own)

    Class I, II, III, IV, V, NK, not classified/never employed
13. Social class (parental)
14. Long-term physical illness/disability SPECIFY

    None
    Mild
    Moderately severe
    Very severe
    NK

History of psychiatric in-patient treatment (up to key contact)

15. Number of known admissions to any psychiatric hospital

None
One
Two
Three or more
NK

16. Date of first (known) admission to any psychiatric hospital .....

17. Interval since first (known) admission to any psychiatric hospital .....

18. Duration of latest spell in psychiatric hospital .....

19. Interval since last in psychiatric hospital .....

17 - 19.

No known admissions
1 week or less
More than 1 week - 1 month
More than 1 month - 3 months
More than 3 months - 6 months
More than 6 months - 1 year
More than 1 year - 2 years
More than 2 years - 5 years
More than 5 years - 10 years
More than 10 years - 20 years
More than 20 years
NK

Current psychiatric status (at date of key contact)

20. Patient status in relation to parent hospital

In-patient)
Day-patient)
Out-patient)
Other status SPECIFY)
NK
Not applicable (include patients under care of G.P. only)

21. Legal category of treatment

Not compulsory
Compulsory
NK
Not applicable

22 Primary diagnostic category

No psychiatric defect diagnosed
Manic-depressive
Depressive (other)
Schizophrenic (paranoid type)
(non-paranoid)
(schizo-affective)

Organic psychosis
Neurotic
Personality disorder (hysterical type)
(other type)

Alcoholism
Drug addiction
Mental subnormality
NK or diagnosis uncertain

23 Psychiatric treatment prescribed/recommended

No treatment
Medication: oral only
injectable depot phenothiazine etc.
(with or without anti-Parkinsonism drug)
both oral and injectable drugs

Occupational/Industrial therapy
Part-time care in hospital environment (except for OT/IT)
Individual psychotherapy
Group psychotherapy
Family/Marital therapy
Other treatment SPECIFY
NK
Not applicable.

Referral to community psychiatric nursing service

24 Number of referrals .....

25 Date of earliest referral .....

26 Date of most recent referral .....

27 Source of most recent referral

Parent hospital staff: psychiatrist
nurse
social worker
other SPECIFY

G.P.
Local authority health/social work staff
Patient/patient's relative
Other SPECIFY
NK

ANNEX 4/4.2.

Case-Record Section B: First interview

Date of interview ..... Patient's index number .....

Nurse's code ..... Date of 'key contact' .....

Patient's name ..... Date of latest referral .....

Continuation of case

28. Do you think you will go on seeing (patient) on a regular footing?

(If NO) Can you tell me about how you came to be in contact with him?

Referral to Community Psychiatric Nursing Service (PATIENTS REFERRED IN 1972 ONLY)

29. Was he an in-patient when you had him referred, or what?

In-patient)
Day-patient)
Out-patient) of parent hospital
Ex-patient)
Other SPECIFY
NK
NA

30. Was he transferred to you from someone else's care?
(If YES) Who from? Why would you say the case was transferred?

31. What were you actually asked to do for him?

Give injection
Other SPECIFY

32. (If Other) Do you think this is something a nurse ought to be asked to do or should someone else do it?

33. Are you doing anything else for him, over and above what you were asked to do?

34. Had you met him personally before you started looking after him like this? How often?

35. At the time he was referred did you feel you had enough information about him?

36. Where did you get most information about him from?

Previous acquaintance
Case-notes
Clinical team meetings
Psychiatrist - personal communication
Ward nurse " " " "
Other source SPECIFY
NK
NA

37. Has any important change been made in his treatment objectives since he was referred to you?

(If YES) Who decided on the change?
Were you involved in the decision?

Patient's circumstances and characteristics

38. What sort of household does he usually live in?

Alone
With spouse
In parent's household
Other private household as family member
Boarding house/hotel (catered for)
Lodgings (self- catering)
Hostel/"home"/institution
Residential employment
Other SPECIFY
NK
NA - include in-patients

39. Who else lives in the same household? Ages (approx.)?

40. Who is the householder? (Who owns or rents the house?)

41. Do you think this is a suitable environment for him at the moment?

42. Is that where he was living last time you saw him?

43. Would you say his usual housing conditions are reasonably satisfactory?

44 How often does he see relatives or hear from them?

(If NEVER) Has he a close friend who you regard as a substitute for a family?

Completely isolated
Contact less than once a month or very irregular
Between weekly and monthly
More than once a week, regularly
Lives with family (or substitute)
NK
NA

45. Has he other sources of social contact? (What are they?)

46. Do you think he feels lonely or isolated?

47. Do you know what his main source of income is at present?

None
Own private income
National Insurance or Social Security benefits
Occupational pension
Supported by husband
Supported by other family or household member
Other SPECIFY
NK
NA

48. Has he got enough money to live on, in your opinion?

49. Is he in arrears or in debt, so far as you know?

50. Was he in paid employment

last time you saw him?
half or more of the past 6 months?

51. (If NO) Why not?

Over retiring age
Physically unfit
Mentally unfit (include in-patients, day-patients)
Seeking/unable to find a job
Little or no attempt to find work
Can't keep a job
Full-time housewife or full-time student
Other SPECIFY
NK
NA - include people in employment

52. (If YES) What kind of work?

Regular, competitive employment
Self-employed
Casual/temporary employment
Residential post
Sheltered employment (paid)
Has job but off sick (paid or unpaid sickness absence)
Other SPECIFY
NK
NA

53. (If self-employed, housewife or student) How well has he been managing work?

Last time you saw him?
During the past six months?

54. (If RETIRED or PHYSICALLY HANDICAPPED) Has he been keeping himself occupied?

Never occupied
Seldom/irregularly occupied
Regularly occupied for at least part of the time
NK
NA

55. How well does he cope with dress and personal hygiene?

Poor (socially unacceptable)
Fair (generally acceptable but some lapses unless supervised).

Competent
NK
NA

56. Can he get about outside the house and cope with travelling in public transport?

Poor (never leaves the house/cannot cope unaided)
Moderate (sometimes needs help)
Competent
NK
NA

57. Can he manage his own money?

Poor (cannnot manage unaided)
Moderate (sometimes needs help)
Competent
NK
NA

58. Judging by last time you saw him, is his behaviour at present liable to be a serious handicap in the community or a nuisance to others? EXAMPLES ?

No disturbed behaviour shown
Minimally disturbed
Moderately disturbed
Severely disturbed
NK

59. Did you observe this yourself or were you dependent on someone else to tell you?

60. What was your assessment of his mental state last time you saw him? Were there any significant mental signs and symptoms?

PROMPT FROM LIST

61. In general would you say his mental symptoms seriously affect his ability to cope with living in the community?

No symptoms
Symptoms present but no significant effect
Some restriction of social competence
Incapacitated (for work etc.)
NK

Nurse's objectives, accountability and support

62. What are your most important aims in the work you do with him? (How do you go about achieving this? Could you describe your methods and the means at your disposal?)

63. Whom do you feel responsible to for your work with him?

64. If you had serious problems or difficulties with him, or his family, whom would you probably discuss them with?

ANNEX 4/4.3

Case-Record Section C: Second interview

Date of interview ..... Patient's name .....

Nurse's code ..... Patient's index number .....

Termination of case

65. Case terminated? Date? .....

66. (If YES) What were the reasons for deciding not to continue with this case?
Whose idea was it to stop?
Was anybody else consulted about the decision/notified of it?
How was the termination managed?

67. If (NO) How long do you think he will continue to need psychiatric nursing care in the community?

Social performance and mental state

68. (Review items 50 to 61 with reference to the latest occasion when patient was seen in the community).

Sources of help

69. List all people or agencies with whom the nurse has been in touch during the study period concerning help for this case; other services received by the patient/client; noting -

whether service accepted by client
whether there was personal contact between nurse and agency
whether agency approached by nurse or nurse by agency.

Special problems

70. Record problems perceived by nurse as applying or having applied in the past

to the patient
to family members

(SHOW SPECIAL PROBLEMS LIST)

71. (If family member defined as having problems) SPECIFY WHO Did you do anything specifically to help.....?

72. Who do you think has most needed help in this case?

73. Who has your own work been primarily concerned with?

Nurse's experience of the case

74. Is (patient/client) reluctant or difficult about accepting help or services offered?

75. Are there kinds of help or service not currently available which you would have liked to see given in this case?

76. Have you yourself any particularly positive or negative feelings about working on this case?

ANNEX 4/4.4

SPECIAL PROBLEMS

CLIENT'S NAME .....

TICK BELOW :

	Problem affects Client	Family member
1. Difficulties in coping with everyday activities, travel, housework etc.		
2. Neglect of self-care		
3. Mental disorder in household member other than client		
4. Distress, anxiety or strain arising from client's mental state or behaviour		
5. Restriction or disruption of social life/employment/domestic duties		
6. Coping with physical illness/disability		
7. Misuse of drugs or alcohol		
8. Personality problems or inadequacy		
9. Problems of sexual behaviour (other than marital difficulties)		
10. Marital relationships		
11. Other intra-family relationships		
12. Difficulties in care or management of children		
13. Crime, delinquency, conflict with authorities		
14. Legal problems		
15. Housing/accommodation problems		
16. Difficulties of finding or keeping job		
17. Financial difficulties		
18. Lack of social contacts, loneliness, seclusiveness		
19. Bereavement		
20. Other social problems?		

Case-Record: Criteria, rating-scales and definitions

Items 12 and 13: Social class

The Registrar-General's classification of social class by occupation was used (1970 edition).

Item 14: Long-term physical illness or disability

Rated by the researcher, by reference to the effect of the illness or disability on the patient's employment chances, personal independence, domestic life and social contacts.

Item 20: Patient status in relation to parent hospital

In-patient	included patients on leave of absence and people about to be admitted to the parent hospital under a compulsory order.
Day-patient	included patients for whom day-care at the parent hospital on one or more days a week was arranged.
Out-patient	included all those who were expected to attend a psychiatric out-patient clinic of the parent hospital. The nurses' injection clinic was included in this description because a psychiatrist was regularly available for consultation at the clinic.

Item 29: Patient status

See Item 20

Item 45: Sources of social contact

A social contact was defined as an interpersonal transaction conveying some implication of warmth, personal concern or mutual affection.

Items 50, 53 to 58: Social competence and behaviour problems

These items were based on the components of the rating scale for 'social adjustment' used by Renton et al (1963), in their follow-up study of schizophrenic patients in Edinburgh.

Item 58: Effect of socially handicapping behaviour

Socially handicapping behaviour was rated by the researcher, using a scale based on that used by Renton and her colleagues for "socially embarrassing symptoms", but expanded to suit the wider range of conditions represented in this study. The ratings used were as follows:-

Severely disturbed Showing behaviour likely to lead to a social crisis or causing serious interference with social adaptation

Examples:-
- Active violence
- Suicidal attempt
- Bizarre behaviour in public actively involving other people
- Grossly disordered sexual behaviour
- Grossly deteriorated personal habits.

Moderately disturbed A public or family nuisance or causing serious interference with social adaptation

Examples:-
- Threats of violence, minor destructiveness
- Suicide threats
- Bizarre behaviour in public not actively involving other people
- Deterioration in sexual behaviour
- Deterioration in personal habits or hygiene
- Severe social withdrawal, muteness
- Uncontrollable irritability, over-activity, restlessness, noisiness
- Excessive slowness or underactivity
- Excessively demanding, uncooperative or inconsiderate behaviour
- Obsessional rituals, phobic behaviour
- Overt signs of severe anxiety and tension.

Minimally disturbed Shows one or more of the above types to a moderate degree, but can and does control them when required to do so.

Item 60: Mental signs and symptoms

Items in the following list of signs and symptoms were checked as present or absent. The list consisted of categories from the 'Brief Psychiatric Rating Scale' (Overall and Gorham 1962). The authors' definitions were referred to in case of doubt about the application of the categories. (Four categories were omitted from the list because they referred to behaviour which was already described under 'Socially Handicapping Behaviour' (item 58).)

- Somatic concern
- Anxiety
- Emotional withdrawal
- Conceptual disorganization
- Guilt feelings
- Grandiosity
- Depressive mood
- Hostility
- Suspiciousness
- Hallucinations
- Unusual (bizarre)thought content
- Blunting of affect

Item 61: Effect of mental symptoms

On the basis of the nurse's description of the patient's symptoms, the researcher rated the extent to which the patient's ability to cope was affected by mental symptoms, taking into account their effect on the patient's employment chances, personal independence, domestic life and social contacts. The ratings were as follows:-

Incapacitated (for work etc.)
Some restriction of social competence
Symptoms present, but no significant effect
No symptoms.

Item 70: Special problems

The list of problems was drawn up after examination of similar lists used by Rehin and Martin (1968) and Jefferys (1965) in studies of mental welfare and social welfare services. The list was revised in the light of observations made during the exploratory stages of the study.

A possible method of surveying patients' problems would have been to ask the participants for their own descriptions. Jefferys found in a pilot survey that free descriptions were prepared increasingly perfunctarily as the survey went on, and were complicated and lengthy to classify and code. She also found that "staff tended to record only those aspects of the problem which particularly concerned them and failed to mention other problems which they subsequently agreed were important" (Jefferys 1965 p.7). Though free descriptions would not be subject to distortion by the researcher's views, the main object was to obtain an accurate picture of the patients' circumstances. In the light of Jefferys' comments it was decided to present pre-defined categories to the participants who would only be required to choose between two possible answers 'Present' or 'Absent'. This was done at an interview when the nurse also had the opportunity to describe other types of problems to the researcher. In the event it was found that pre-defined categories covered almost all of the types of problems mentioned.

The list followed most closely the categories used by Rehin and Martin, all but two of which were included (Rehin and Martin 1968 p. 177). The two omitted were 'Difficulties of interpersonal relationships' which were represented more specifically by items 8 - 12, and 'Lack of acceptance of client's mental disorder' which seemed out of place among the other items (being an attitude whose existence could not be directly observed but only inferred).

ANNEX 4/6

REFERRAL OF NEW CASES - ENQUIRY SCHEDULE

Name of respondent: ..... Date of interview .....

Patient's name ..... Serial number .....

Nurse's Code No. ..... Date of referral .....

.....

1. Was it your personal decision to refer patient to nurse?

   If not, who else was involved and how was the decision made?

.....

2. What was the nurse asked to do for the patient?

   (a) in the short term?

   (b) in the long term?

   (c) IF MODECATE MENTIONED:

   Would patient have been referred to this service if this drug had not been prescribed?

.....

3. Do you think the nurse is doing anything helpful for the patient beyond what he/she was actually asked to do?

   What?

.....

4. Why was the Community Nursing service selected for this case?

.....

5. If the service had not existed, what would you have done?

.....

6. Have you had any feedback from the nurse since the referral?

   By what means?

.....

7. Would you have referred the case to any Community Nurse who was available?

.....

8. Do you feel that the objectives of the referral are being met?

.....

9. Was there sufficient opportunity for discussion of the case with the nurse at the referral stage?

.....

10. Do you consider it desirable for the nurse and patient to be reasonably acquainted before the nurse takes over the case?

    If so, was there enough opportunity for them to get acquainted in this case?

.....

IN GENERAL

11. What do you see as the most important functions of the Community Nursing team (as at present organised) ?

.....

12. What kinds of patients with what types of needs are most suitable for referral to the Community Nursing service?

.....

13. Are there any types of patient or situation which you would consider <u>not</u> suitable for them?

.....

14. Have you had any problems deciding what type of worker to refer patients to?

.....

15. What sort of personal qualities and skills do you think are needed for psychiatric nursing in the community setting?

.....

16. How does the level of responsibility carried by Community Nurses compare with the ward situation?

.....

17. What are the chief advantages of the service from your own point of view?

.....

18. Have you encountered any disadvantage in practice?

.....

19 DOCTORS ONLY

What do you think the Community Nurses' relationship with the patient's G.P. should be? Should there be direct communication between them?

.....

20. Any other points?

ANNEX 4/7

GENERAL PRACTITIONERS - ENQUIRY SCHEDULE

NAME ..... PATIENT(S).....

DATE ....

.....

1. Were you aware that your patient(s) was/were being visited by a nurse from the REH?

   If YES
   - 1a How did you learn about this?
   - 1b Were the nurses themselves in contact with you?

     Details?

.....

2. How did you feel when you learnt about the nurse's visits? Was this welcome or unwelcome, or didn't you have any special feeling about it?

.....

3. Do you see a need for nurses with psychiatric training and experience to be available to work with patients in the community?

.....

4. Did you know that the REH had a group of nurses specially assigned to this work?

   If YES
   - 4a Have you ever had any explanation about what they are supposed to do?
   - 4b Would this be helpful?
   - 4c What is your own understanding of their function?
   - 4d Would you think of asking for their help with one of your patients?

     If so, who would you get in touch with?

.....

5. Have you had any other experience of nurses from the REH working in the community?

   if YES
   - 5a Have the nurses made any difference to your contact with the REH about patients?
     (Do you think there was better continuity with them?)

6. Who do you think they should primarily be reporting to about the patients they are seeing?

   How far do you think there should be direct communication between them and yourself?

   What should their relationship with GPs be?

DISTRIBUTION OF CERTAIN VARIABLES AMONG SAMPLE AND NON-SAMPLE PATIENTS

The distribution of variables in the sample and non-sample groups is compared in the following tables. Differences were tested for statistical significance using standard X^2 tests. None of the differences reached significance at the 5% level.

1) SEX

	Number of patients		All patients
	Sample	Non sample	
MALE	68	64	132
FEMALE	86	90	176
	154	154	308

X^2: 0.119, d.f. 1, $p>0.05$

2) AGE GROUP

15 - 24	8	10	18
25 - 34	29	32	61
35 - 44	34	25	59
45 - 54	34	32	66
55 - 64	26	32	58
65 - 74	18	20	38
75 +	4	3	7
	153	154	307

X^2: 2.575, d.f. 6, $p>0.05$

3) SOCIAL CLASS

		Number of patients		All patients
		Sample	Non-sample	
(Registrar General's Classes)	I and II	23	13	36
	III	64	72	136
	IV and V	60	60	120
		147	145	292

X^2: 3.142, df. 2. $p > 0.05$

4) DIAGNOSTIC CATEGORY

Schizophrenic	99	90	189
Non-Schizophrenic	55	64	119
	154	154	308

X^2: 0.876, df 1. $p > 0.05$

5) TREATMENT

No medication	16	18	34
Oral medication only	47	54	101
Intra-muscular injection	82	73	155
	145	145	290

X^2: 1.120, df. 2. $p > 0.05$

6) PATIENT - STATUS

In-patient	14	26	40
Day-patient	19	20	39
Out-patient	88	69	157
Other	33	39	72
	154	154	308

X^2: 6.42, df . 3. $p > 0.05$

ANNEX 5: THE PATIENTS

List of Tables

(1) ALL CASES

The information in Tables A5/01 to A5/15 relates to the 308 identified patients, at the time of their 'key contact'. This group of data was extracted from the hospital's case-notes.

(2) SAMPLE OF CASES

Tables A5/16 to A5/21 relate to the sub-sample of 111 cases discussed at the first and second research interviews.

.19 Living group

.20 Special problems

Table A5/01

AGE GROUPS AND SEX

(percentage and number of cases)

AGE	MALE		FEMALE		BOTH SEXES	
	%	(n)	%	(n)	%	(n)
15 - 24	7	(9)	5	(9)	6	(18)
25 - 34	28	(37)	14	(24)	20	(61)
35 - 44	20	(26)	19	(33)	19	(59)
45 - 54	21	(28)	22	(38)	22	(66)
55 - 64	14	(19)	22	(39)	19	(58)
65 - 74	10	(13)	14	(25)	12	(38)
75+	-	-	4	(7)	2	(7)
ALL AGES	43	(132)	57	(176)	100	(308)

Table A5/02

MARITAL STATUS

(percentage and number of cases)

	%	(n)
Never married	50	(153)
Married	30	(91)
Widowed	12	(37)
Had legal separation	1	(4)
Divorced	7	(21)
	100	(306)

Table A5/03

DE FACTO MARITAL SITUATION

(percentage and number of cases)

	%	(n)
Single	76	(234)
Living with spouse	21	(64)
'Cohabiting'	2	(5)
Temporarily separated$^{\emptyset}$	1	(4)
	100	(307)

$\emptyset$ Spouse in prison or hospital

Table A5/04

MARITAL HISTORY AND DIAGNOSIS

(SCHIZOPHRENIC OR OTHER)

(Percentage and number of cases)

Marital History	Diagnosis				All diagnoses	
	Schizophrenic		Not schizophrenic			
	%	(n)	%	(n)	%	(n)
Had married	44	(84)	59	(69)	50	(153)
Never married	56	(105)	41	(48)	50	(153)
	100	(189)	100	(117)	100	(306)

Table A5/05

PATIENTS' SOCIAL CLASS$^{\emptyset}$ AND DIAGNOSIS

(SCHIZOPHRENIC OR OTHER)

(Percentage and number of cases)

Patients' Social Class	Diagnosis				All diagnoses	
	Schizophrenic		Not schizophrenic			
	%	(n)	%	(n)	%	(n)
Class I	3	(5)	3	(3)	3	(8)
Class II	7	(13)	13	(15)	9	(28)
Class III	40	(75)	51	(61)	45	(136)
Class IV	20	(37)	19	(22)	20	(59)
Class V	26	(49)	10	(12)	20	(61)
Not classified	4	(8)	3	(3)	4	(11)
		(179)		(113)		(292)

$\emptyset$ Registrar General's Classification (1970)

TABLE A5/06

DIAGNOSTIC CATEGORY AND AGE GROUP
(percentage and number of cases)

Diagnostic category	Age Groups 15-54		55+		All ages	
	%	(n)	%	(n)	%	(n)
Schizophrenia:						
paranoid type	30	(61)	18	(19)	26	(80)
non-paranoid type	32	(66)	13	(13)	26	(79)
schizo-affective	11	(23)	7	(7)	10	(30)
All schizophrenic	74	(150)	38	(39)	61	(189)
Non-schizophrenic:						
Manic-depressive psychosis	3	(7)	6	(6)	4	(13)
Other depressive illness	2	(5)	22	(23)	9	(28)
Organic psychosis	2	(5)	12	(12)	6	(17)
Neurotic illness	3	(7)	5	(5)	4	[b](13)
Personality disorder:						
hysterical	3	(7)	5	(5)	4	(12)
other type	7	(14)	10	(10)	8	(24)
Alcoholism	3	(6)	2	(2)	3	(8)
Mental subnormality	1	(3)	1	(1)	1	(4)
All non-schizophrenic	26	(54)	62	(64)	39	(119)
All categories	100	(204)	100	(103)	100	(308)

[b] The age of one patient was uncertain.

Table A5/07 TYPE OF MEDICATION AND DIAGNOSIS (SCHIZOPHRENIC OR OTHER)

(Percentage and number of cases)

Recommended medication	Diagnosis				All diagnoses	
	Schizophrenic		Not schizophrenic			
	%	(n)	%	(n)	%	(n)
Depot tranquillizer (intramuscular injection)*	55	(100)	7	(8)	37	(108)
Depot tranquillizer plus drugs taken by mouth	23	(42)	5	(5)	16	(47)
Drugs by mouth only	18	(33)	63	(68)	35	(101)
No medication	4	(7)	25	(27)	12	(34)
TOTALS	100	(182)	100	(108)	100	ø (290)

* Depot phenothiazine injections given together with an oral anti-Parkinsonism drug were classified here

ø In 18 cases current treatment was not recorded (includes cases where key contact took place at emergency admission)

TABLE A5/08

SPECIAL TYPES OF TREATMENT AND DIAGNOSIS

(SCHIZOPHRENIC OR OTHER)

(Percentage and number of cases)

Special Treatments	Diagnosis				All diagnoses	
	Schizophrenic		Not schizophrenic			
	%	(n)	%	(n)	%	(n)
Day care in (i) day centre/ward	11	(18)	12	(12)	11	(30)
(ii) occupational or industrial therapy departments	6	(10)	-	(-)	4	(10)
Individual psychotherapy	1	(1)	-	(-)	-	(1)
Family or marital therapy	-	(-)	2	(2)	1	(2)
No special treatment	83	(137)	86	(86)	84	(223)
TOTALS	100	(166)	100	(100)	100	Ø(266)

Ø In-patients, and others for whom information was lacking, were omitted.

TABLE A5/09

STATUS AT 'KEY CONTACT' AND DIAGNOSIS

(SCHIZOPHRENIC OR OTHER)

(Percentage and number of cases)

Hospital Patient Status	Diagnosis				All diagnoses	
	Schizophrenic		Not schizophrenic			
	%	(n)	%	(n)	%	(n)
Royal Edinburgh Hospital						
In-patient*	13	(24)	13	(16)	13	(40)
Day-patient	14	(27)	10	(12)	13	(39)
Out-patient$^{\emptyset}$	60	(113)	37	(44)	51	(157)
Community patient	12	(23)	32	(38)	20	(61)
Other Hospital						
In-patient	1	(1)	1	(1)	1	(2)
Other	1	(1)	7	(8)	3	(9)
TOTALS	100	(189)	100	(119)	100	(308)

* Includes 2 in-patients on leave of absence and 6 people (5 schizophrenic and 1 other) in process of admission to hospital under compulsory order

$\emptyset$ Out-patients were defined as people attending a psychiatrist's out-patient clinic

TABLE A5/10

NUMBER OF KNOWN ADMISSIONS TO PSYCHIATRIC HOSPITALS

(Percentage and number of cases)

No. of Admissions recorded	%	(n)
None	3	(10)
One	16	(48)
Two	13	(41)
Three or more	68	(208)

NOTE: 87% of schizophrenic patients (164 individuals) were known to have had more than one admission to psychiatric hospitals; compared with 71% of non-schizophrenics (85 individuals)

TABLE A5/11

INTERVAL BETWEEN FIRST PSYCHIATRIC ADMISSION AND 'KEY CONTACT'

(Percentage and number of cases)

Duration of interval	%	(n)
Never admitted	3	(10)
Up to 3 months	4	(12)
3 months - 1 year	6	(18)
1 - 2 years	4	(13)
2 - 5 years	18	(54)
5 - 10 years	18	(54)
10 - 20 years	28	(57)
More than 20 years	17	(51)

TABLE A5/12

INTERVAL BETWEEN PATIENT'S LATEST DISCHARGE FROM PSYCHIATRIC HOSPITAL AND 'KEY CONTACT'

(Percentage and number of cases)

Duration of interval	%	(n)
Never admitted	3	(10)
In-patient at 'key' contact	11	(34)
Up to 3 months	22	(68)
3 months - 1 year	25	(78)
1 - 2 years	19	(57)
2 - 5 years	14	(44)
5 - 10 years	4	(13)
More than 10 years	1	(4)

TABLE A5/13

DURATION OF PATIENT'S MOST RECENT STAY IN PSYCHIATRIC HOSPITAL

(Percentage and number of cases)

Duration of stay	%	(n)
Never admitted	3	(10)
Up to 3 months	68	(207)
3 months - 1 year	15	(44)
1 - 2 years	5	(15)
2 - 10 years	4	(11)
More than 10 years	6	(18)

TABLE A5/14

LEGAL CATEGORY OF IN-PATIENT TREATMENT

(Percentage and number of cases)

Category of treatment	%	(n)
Informal	90	(276)
Compulsory	4	(19)
Admitted at key contact (6) In-patient at key contact (5) On leave of absence or conditional discharge (8)		
Never admitted	6	(13)

TABLE A5/15

PHYSICAL DISABILITY AND AGE

(Percentage and number of cases)

Physical disability	A G E S						All ages	
	15 - 44		45 - 64		65 +			
	%	(n)	%	(n)	%	(n)	%	(n)
None	84	(116)	65	(80)	44	(20)	70	(216)
Mild	9	(12)	19	(23)	29	(13)	16	(48)
Moderate	7	(9)	13	(16)	22	(10)	11	(35)
Severe	1	(1)	4	(5)	4	(2)	3	(8)
	100	(138)	100	(124)	100	(45)	100	(307)

TABLE A5/16

SPECIFIC SOCIAL CAPACITIES

(Sample cases: number)

Patient's performance	SOCIAL CAPACITIES		
	Mobility	Managing money	Care of dress - personal hygiene
Competent	(91)	(68)	(72)
Moderate (needs help)	(13)	(12)	(27)
Poor	(3)	(15)	(12)
Not known	(4)	(16)	-
	(111)	(111)	(111)

TABLE A5/17

EMPLOYMENT RECORD

(sample cases: percentage and number)

Employment record[Ø]	%	(n)
Consistently in employment	12	(13)
Intermittently in employment	8	(9)
Consistently unemployed	80	(89)
	100	(111)

Ø Consistently in employment was defined as being in paid employment at the time of the interview, and for at least 3 out of the previous 6 months.

Consistently unemployed was defined as being out of work at the time of the interview and for at least 3 out of the previous 6 months. Other cases were described as intermittently employed

TABLE A5/18

INCOME SOURCE

(Sample cases: percentage and number)

Principal source of income	%	(n)
Wages, salary or occupational pension	11	(12)
Private income	15	(17)
*Maintenance by husband or other household member	19	(21)
Social security payments	43	(48)
No income	1	(1)
Not known	11	(12)
	100	(111)

* Married women in part-time work were classified under this heading.

TABLE A5/19

LIVING-GROUP

(Sample cases: percentage and number)

Patient's living group	%	(n)
Living alone	18	(20)
Living with family	57	(63)
Boarding house/lodgings	10	(11)
Residential home/hostel	14	(16)
Residential employment	1	(1)
	100	(111)

TABLE A5/20

SAMPLE CASES: DESCRIPTION OF SPECIAL PROBLEMS

PROBLEMS WHICH HAD AFFECTED CLIENTS SINCE FIRST REFERRAL TO THE SERVICE	NUMBER AFFECTED		
	Patients	Family members	Total cases
Intra-family relationships (other than marital problems)	40	27	67
Personality problems, inadequacy	56	10	66
Distress, anxiety or strain arising from the patient's mental state or behaviour	20	37	57
Lack of social contact, loneliness, seclusiveness	48	8	56
Difficulties in coping with everyday activities, travel, housework, etc.	47	5	52
Neglect of self-care	38	3	41
Housing/accommodation problems	28	8	36
Coping with physical illness or disability	30	5	35
Difficulties of finding/keeping jobs	28	5	33
Financial difficulties	23	10	33
Restriction and/or disruption of social life/employment/ domestic duties	11	15	26
Marital relationships	15	8	23
Mental disorder in household member other than patient	3	20	23
Difficulties in care/management of children	12	8	20
Misuse of drugs or alcohol	14	4	17
Crime, delinquency, conflict with authority	11	4	15
Bereavement	11	2	13
Legal problems	9	-	9
Problems of sexual behaviour (other than marital problems)	6	-	6

N = 111 (sample cases, interview data)

ANNEX 6: PATTERNS OF WORK:

THE STRUCTURE OF THE NURSE'S WORKING DAY

LIST OF TABLES

TABLE A6/1

Allocation of nurses' time to categories of work

Category of work	Total time spent (minutes)	Number of occasions recorded	Mean duration/ occasion (minutes)	Percentage of total working time
Office work, case-notes, administrative contacts	5,108	130	39	22
Travelling/car maintenance/ providing transport	4,907	351	14	21
Visits - actual	3,973	148	27	17
abortive	245	29	8	1
Clinical and ward team meetings	3,234	25	129	14
Discussions with colleagues about clients	2,097	104	20	9
Other meetings, conferences, training sessions	1,415	27	52	6
Attendance at injection clinic	1,015	4	254	4
Research records etc.	575	28	21	3
Finding and visiting accommodation, etc.	305	16	19	1
Other (1)	234	8	29	1
Activity not recorded	170	6	28	1
Total(2)	23,278	876	-	100

NOTES (1) Instances of 'other' activities: participating in voluntary organisation; study; search for absconding in-patient; preparing carpet gifted to elderly patient; attention to patient's pet dog.

(2) A proportion of working hours recorded as personal time has not been included in the total.

TABLE A6/2

LOCATION OF NURSES' WORK BY CATEGORIES

(number of events).

Category of Work	Location		All locations
	Hospital premises	Elsewhere	
Office work etc.	130	-	130
Visits and interviews (actual)	5	143	148
Clinical and ward team meetings	25	-	25
Discussions with colleagues about clients	92	12	104
Other meetings etc.	26	1	27
Attendance at injection clinic	4	-	4
Keeping research records	27	1	28
Finding and visiting accommodation etc.	15	1	16
Other	4	4	8
TOTAL	328	162	490
Percentage of total	67%	33%	
Abortive visits			29
Travelling			351
Activity not recorded			6
			876

TABLE A6/3

VISITS/INTERVIEWS WITH CLIENTS, EXCLUDING CLINIC CONTACTS

(number and duration)

	Type of visit			All visits
	Routine	Non-Routine	Emergency etc.	
Number of occasions	115	31	2(1)	148
Total time spent (minutes)	2723	1200	50	3973
Mean duration (minutes)	24	39	25	27
(Standard deviation)	(13)	(42)	(5)	(23)
Maximum duration (minutes)	60	220(2)	30	220
Minimum duration (minutes	5	4	20	4
Median duration	20	30	25	20

NOTES:

(1) This was in fact the same event, recorded by 2 nurses, with a difference of 10 minutes between their estimates of duration.

(2) The extreme case was exceptional. It took place outside normal working hours, and appeared to have a social as well as professional aspect.

TABLE A6/4

INJECTION CLINIC

RELATIVE FREQUENCY OF CATEGORIES OF WORK[1]

(Percentage of total)

Category of Work	Number of observations	Percentage of total observations
Interaction with patient (including time taken for treatment) (2)	1976	21%
Consultation with colleagues	1256	13%
Clerical records, appointments etc.	3744	39%
Preparing and cleaning equipment, waiting, other	2604	27%
TOTAL[3]	9580	100%

Notes: (1) The observations on which these figures are based were made at four clinic sessions in May/June 1972. Observations were made at 15-second intervals. Three nurses were present at each session. All participating nurses were present at least once.

(2) The number of patients seen during the four periods of observation was 141.

(3) Periods of absence from the clinic for personal or other reasons were not included in the total.

TABLE A6/5

INJECTION CLINIC: PATIENT/NURSE CONTACTS (1)

(number and duration)

Periods of patient/nurse contact observed:	
number	129
total duration	441 mins.
Average duration of patient/nurse contact:	
Mean: all attenders	3.4 mins.
early attenders (2)	3.0 mins.
late attenders (2)	3.7 mins.
Median duration	3.0 mins.
Maximum duration	17.75 mins.
Minimum duration	0.25 mins.

NOTES (1) The observations on which these figures are based were focussed on the patients, and were made at four clinic sessions in Dec. 1972/Jan 1973. Two nurses were present at each session.

(2) Patients were divided into two groups - the first half and second half of the number who attended each session. Duration was calculated separately for each group.

ANNEX 7 NURSES' CONTACTS WITH PATIENTS

LIST OF TABLES

TABLE A7/1 NURSES' CONTACTS WITH PATIENTS: INITIATOR OF CONTACT EVENT IN RELATION TO LOCATION OF CONTACT

(Percentage and number of contacts)

Initiator of contact	LOCATION						All locations	
	Injection Clinic		Hospital (elsewhere)		Community visit			
	%	(n)	%	(n)	%	(n)	%	(n)
Community nurse	..	(1)	49	(20)	78	(338)	45	(359)
Ward nurse	-	-	2	(1)	4	(18)	2	(19)
Psychiatrist	..	(1)	17	(7)	11	(48)	7	(56)
Other	-	-	32	(13)	6	(27)	5	(40)
Clinic appointment	100	(325)	-	-	-	-	41	(325)
		(327)		(41)		(431)[1]		(799)

NOTE (1) Initiator of 2 community visits unknown

TABLE A7/2: NURSES' CONTACTS WITH PATIENTS: PATIENT'S STATUS AT THE TIME OF CONTACT IN RELATION TO LOCATION

(Percentage and number of contacts)

Patient status (at parent hospital)	LOCATION						All locations	
	Injection clinic		Hospital (elsewhere)		Community visit			
	%	(n)	%	(n)	%	(n)	%	(n)
Out-patient	87	(284)	24	(10)	50	(211)	64	(505)
In-patient	6	(20)	17	(7)	4	(16)	5	(43)
Day patient	7	(23)	29	(12)	9	(37)	9	(72)
Other	-	-	29	(12)	38	(160)	22	(172)
		(327)		(41)		(424)(1)		(792)

NOTE: (1) Patient status was not known for 9 community visits

TABLE A7/3: NURSES' CONTACTS WITH PATIENTS:
INTERVAL BEFORE NEXT RECORDED CONTACT, IN RELATION TO LOCATION
(Percentage and number of contacts)

Duration of interval	LOCATION						All locations	
	Injection clinic		Hospital (elsewhere)		Community visit			
	%	(n)	%	(n)	%	(n)	%	(n)
1 - 13 days	6	(19)	47	(18)	53	(223)	33	(260)
14 - 27 days	67	(217)	18	(7)	26	(110)	43	(334)
28 days or more	26	(85)	16	(6)	13	(56)	19	(147)
Next event admission to hospital/ loss of contact	2	(5)	18	(7)	7	(31)	5	(43)
		(326)		(38)		(420)		(784)

TABLE A7/4: PRESENCE OF IDENTIFIED PATIENT AND HIS FAMILY IN RELATION TO LOCATION OF CONTACT

(Percentage and number of contacts)

Presence of patient and/ or family member(s) (1)	LOCATION						All Locations	
	Injection clinic		Hospital (elsewhere)		Community visit			
	%	(n)	%	(n)	%	(n)	%	(n)
Patient only	98	(320)	93	(38)	60	(260)	77	(618)
Patient and family member (s)	2	(7)	7	(3)	32	(137)	18	(147)
Family only	-	-	-	-	8	(36)	5	(36)
		(327)		(41)		(433)		(801)

Note (1) Definition of family members included relatives and friends living in the same household as the identified patient

TABLE A7/5: NURSES' CONTACTS WITH PATIENTS:
NUMBER OF COMMUNITY PSYCHIATRIC NURSES PRESENT AT CONTACTS IN RELATION TO LOCATION
(Percentage and number of contacts)

Number of Community Nurses present	LOCATION			All Locations
	Injection clinic	Hospital (elsewhere)	Community visit	
	% (n)	% (n)	% (n)	% (n)
One	2 (7)	85 (35)	91 (392)	54 (434)
Two	98 (319)	15 (6)	9 (40)	46 (365)
Three	.. (1)	- -	.. (1)	.. (2)
	(327)	(41)	(433)	(801)

TABLE A7/6

NURSES' CONTACTS WITH PATIENTS:

PROFESSIONAL WORKERS ALSO PRESENT AT

NURSES' COMMUNITY VISITS

(Number and percentage of community visits)

Category of professional staff	Community visits	
	%	(n)
ALL PROFESSIONAL STAFF (1)	17	(72)
Staff of parent hospital:		
Psychiatrist	..	(2)
Nurse (1)	3	(13)
Social worker	..	(1)
Others	2	(8)
Staff of domiciliary services (2)		
General practitioner	1	(3)
Health visitor	1	(4)
Social worker	..	(2)
Home help	4	(16)
Residential Staff	4	(17)
Police	..	(2)
Others	2	(8)

Community visits: N = 431

NOTES (1) Community psychiatric nurses are not included

(2) No district nurses or midwives were encountered

TABLE A7/7

SOURCES OF HELP TO PATIENTS/FAMILIES, AND NURSES' COMMUNICATION WITH THEM

(number of cases)

Source of help	Service reported	Contact with community psychiatric nurse
Hospital services		
Psychiatrist	53	39
Ward staff	23	21
Social worker	10	6
Another hospital	19	6
Community health services		
General practitioner	94	16
Health visitor	11	7
District nurse	1	-
Local authority services		
Residential care	20	18
Social worker	11	4
Home help	7	4
Meals on wheels	2	1
Day nursery	3	1
Voluntary services		
Church	5	1
Day Centre	2	-
Other voluntary organizations	10	4
Relatives	14	6
Neighbours, friends	7	5
Employer	3	1

Total Number of cases in sub-sample = 111

ANNEX 8: PATIENTS' CONTACT WITH SERVICE

LIST OF TABLES

TABLE A8/1

PATIENTS' CONTACT WITH SERVICE:

CONTINUITY OF COMMUNITY PSYCHIATRIC NURSING CARE BEFORE KEY CONTACT.

(Number and percentage of cases)

Date of earliest contact	Nature of care		All cases[1]	
	Continuous (n)	Interrupted (n)	(n)	%
1970 or before	(19)	(15)	(34)	29
1971	(28)	(13)	(41)[3]	35
Jan.–Aug. 1972	(28)	(8)	(36)	31
Not known	(2)	(4)	(6)	5
	(77)	(40)	(117)[2]	100

NOTES:

(1) Sample cases only

(2) 34 new cases referred during the sampling period are excluded

(3) 3 cases (earliest contact 1971) are excluded because the nature of care was uncertain

TABLE A8/2

PATIENTS' CONTACT WITH SERVICE:

INTERRUPTION OF NURSING CARE AT END OF STUDY PERIOD, IN RELATION TO DATE OF MOST RECENT REFERRAL

(Number of cases)

Date of most recent referral	Care interrupted or terminated (n)	Care not interrupted (n)	All cases (n)	%
1970 or earlier	(2)	(18)	(20)	13
1971	(4)	(33)	(37)	25
Jan-Aug 1972	(12)	(34)	(46)	31
Sept.-Dec 1972	(34)	(13)	(47)	31
	(52)	(98)	(150)	100%

TABLE A8/3

PATIENTS' CONTACT WITH SERVICE:

TERMINATION OR INTERRUPTION AT END OF STUDY, IN RELATION TO TYPE OF MEDICATION(1)

(Percentage and number of cases)

Situation of case at close of study	Medication prescribed				All treatments	
	Depot phenothiazine		Other or none			
	%	(n)	%	(n)	%	(n)
Terminated or interrupted	16	(13)	51	(32)	31	(45)
Continuing	84	(68)	49	(31)	69	(99)
		(81)		(63)		(144)(2)

$X = 18.327$, d.f. 1, $p < 0.01$

NOTE: (1) The type of medication was recorded at the time of the patient's key contact.

(2) In 10 cases the type of medication was not known or not recorded.

TABLE A8/4

PATIENTS' CONTACT WITH SERVICE:

NUMBER OF STUDY WEEKS IN CARE

(Percentage and number of cases)

Number of weeks	Percent.	(Number)
1 - 5 weeks	8	(13)
6 - 10 weeks	6	(9)
11 - 15 weeks	6	(9)
16 - 20 weeks	5	(8)
21 - 25 weeks	8	(13)
26 weeks	55	(85)
None (single events on agency basis only)	11	(17)
	100	(154)

NOTE: Sample cases only

TABLE A8/5

PATIENTS' CONTACTS WITH SERVICE:

FREQUENCY OF CONTACT IN RELATION

TO DATE OF LATEST REFERRAL

(Percentage and number of cases)

Frequency of contact (Index numbers)	Date of most recent referral						All dates	
	Sept.-Dec 1972		Jan.-Aug. 1972		1971 or before			
	%	(n)	%	(n)	%	(n)	%	(n)
Low/Medium (≤ 0.65)	11	(12)	36	(38)	52	(58)	100	(105)
High/very high (> 0.65)	66	(19)	24	(7)	10	(3)	100	(29)
	23	(31)	34	(45)	43	(58)	100	(134)

$X = 38.963$, 2 d.f., $p < 0.01$

TABLE A8/6

PATIENTS' CONTACT WITH SERVICE:

REGULARITY OF CONTACT WITH THE SAME NURSES

IN RELATION TO LOCATION OF CONTACT

(Number of cases)

Location of contact	Number of nurses encountered during study period				
	1	2	3	4	5
	(n)	(n)	(n)	(n)	(n)
Clinic only	(0)	(1)	(8)	(10)	(20)
Home visit only	(27)	(12)	(3)	(0)	(0)
Mixed locations	(17)	(16)	(11)	(13)	(19)
Total cases	(44)	(29)	(19)	(23)	(39)
Percentage of cases	29%	19%	12%	15%	25%

ANNEX 9

NURSES' ACTIVITIES AT CONTACT BETWEEN NURSE AND CLIENT

LIST OF ANNEXES

ANNEX 9/1

PROCESS AND CONTENT OF NURSE/CLIENT INTERACTION: VARIABILITY IN NUMBERS OF ITEMS RECORDED BY INDIVIDUALS AND BETWEEN INDIVIDUALS

The inter-user reliability of the self-administered check-list (Annex 4/3.2) as an objective method of recording events was not relevant to the use made of it in this study, and was therefore not investigated. The method was designed chiefly to show the areas of function with which the participating nurses were most concerned.

The following table shows that there was considerable variability between the average numbers of items recorded by the different participants, and also between the number recorded by the same individual on different occasions. It is uncertain whether these variations reflected actual differences in performance, or subjective differences between individuals in perception and style of reporting. However, the amount of variation underlines the need to examine the reliability of the method if it were planned to use it as an objective record of performance, for instance in comparative studies or in connection with measures of outcome.

TABLE A9/1.1/

TABLE A9/1.1

NUMBER OF ITEMS PER CONTACT RECORDED IN EACH FUNCTIONAL GROUP BY EACH NURSE

(mean number and coefficient of variation)

	Participating nurses										All participating nurses	
	Nurse A		Nurse B		Nurse C		Nurse D		Nurse E			
	$\bar{x}$	v	$\bar{x}$	v	$\bar{x}$	v	$\bar{x}$	v	$\bar{x}$	v	$\bar{x}$	v
Activities[ø]	0.2	-	0.6	-	0.5	-	0.7	-	1.3	-	0.7	-
Observation/ Assessment	4.1	0.42	3.5	0.56	4.4	0.50	3.8	0.36	3.2	0.55	3.8	0.49
Procedures	2.5	0.42	2.6	0.62	4.0	0.65	3.7	0.38	2.1	0.69	3.0	0.62
Topics	5.2	0.41	5.1	0.57	5.5	0.73	6.3	0.44	2.3	0.72	4.4	0.64

$\bar{x}$: mean number of items recorded per contact

v : coefficient of variation between number of items recorded per contact

ø Coefficients of variation were not calculated for items in the 'Activities' group because, where the mean number is close to zero, the coefficient is not considered a useful indicator.

ANNEX 9/2

PROCESS AND CONTENT OF NURSE-CLIENT INTERACTION: ANALYSIS OF FREQUENCY, CORRELATIONS AND LINKAGES OF FUNCTIONAL ITEMS

List of Tables

TABLE A9/2.1

ACTIVITIES RECORDED AT A SERIES OF 500 NURSE-CLIENT CONTACTS

(number and percentage of contacts)

	Number of contacts		% of contacts	
Technical nursing		100		20
Give injection	83		17	
Administer drug(s) by other route	6		1	
Other technical nursing procedure	17		3	
Social activities		71		14
Control and regulation of client's behaviour		44		9
Escorting client	35		7	
Tracing whereabouts	13		3	
Physical restraint	5		1	
Other	1		0	
Provide transport		42		8
Joint activities		28		6
Domestic tasks	7		1	
Using public facilities and services	3		1	
Personal grooming, care of clothes	2		..	
Other	20		4	
Personal service		21		4
Wash, bath, shave client, wash/dress hair, change clothes	6		1	
Prepare or serve food or drink	3		1	
Other	15		3	

	Number of activities recorded per contact						
	0	1	2	3	4	5	6
Number of contacts	276	156	43	15	9	0	1

Average number of activities:	Mean 0.66	Median 0	Mode 0
	Standard deviation: 0.93		

Note Where categories have been combined (e.g. "Technical Nursing") the combined total may be less than the sum of totals for the sub-categories, if items in more than one of the latter were recorded for the same event. For instance, the total number of events at which 'Technical Nursing' activities were recorded was 100, though the sum of totals for the three sub-categories of Technical Nursing was 106.

TABLE A9/2.2

AREAS OF OBSERVATION OR ASSESSMENT RECORDED AT A SERIES OF 500 NURSE-CLIENT CONTACTS

(number and percentage of contacts)

	Number	%
Mental state	390	78
Behaviour	291	58
Physical health or condition	262	52
Response to medication/treatment	253	51
Material-environmental-social circumstances	249	50
Treatment situation	234	47
Relationships, attitudes or modes or interaction in family	222	44

	Number of areas of observation recorded per contact							
	0	1	2	3	4	5	6	7
Number of contacts	37	30	44	87	108	103	61	30

Average number of areas of observation:	Mean 3.80 Median 4 Mode 4	Standard deviation: 1.86

TABLE A9/2.3

INTERPERSONAL PROCEDURES RECORDED AT A SERIES OF 500 NURSE-CLIENT CONTACTS

(number and percentage of contacts)

	Number	%
Express sympathetic interest, reassurance, confidence or encouragement	298	60
Give information, explanation or instruction	240	48
Allow or encourage ventilation or release of feeling	221	44
Use systematic questioning to elicit specific information	164	33
Advise, criticise, persuade or warn	147	29
Offer practical assistance or referral to another agency	93	19
Encourage the client to think about the nature or effects of his situation and behaviour	88	18
Listen and respond to disturbed and delusional talk	78	16
Use an authoritative or directive manner	71	14
Hold a friendly conversation on normal social topics	51	10
Interpret origin or dynamics of the client's patterns of response and behaviour	28	6
Other	10	2

	Number of interpersonal procedures recorded per contact									
	0	1	2	3	4	5	6	7	8	9
Number of contacts	12	113	105	99	73	52	24	8	9	5

Average number of procedures:	Mean	2.98	Standard deviation	1.84
	Median	3		
	Mode	1		

TABLE A9/2.4

TOPICS RECORDED AT A SERIES OF 500 NURSE-CLIENT CONTACTS

(number and percentage of contacts)

	Number	%
Activities, hobbies, social life	276	55
Mental state, symptoms or signs	266	53
Medical or psychiatric treatment	261	52
Physical health, symptoms and signs	210	42
*Family relationships	207	41
Attitude to hospital(s)	157	31
Personal appearance	151	30
Work, employment	141	28
Other interpersonal relationships	107	21
Financial matters, budgeting	107	21
Social isolation, loneliness	105	21
Behaviour problems and their management	105	21
Housing	101	20
Dependence on drugs including alcohol and excessive smoking	66	13
Care of children	51	10
Health and Social Welfare services and how to obtain them	36	7
Legal matters	29	6
*Marital problems	26	5
Other	21	4
Sexual problems	14	3

	Number of topics recorded per contact							
	0	1	2	3	4	5	6	7
Number of contacts	32	47	45	52	62	58	66	48
	8	9	10	11	12	13	14	15
Number of contacts	31	20	17	8	2	6	4	2
Average number of topics:	Mean 4.87 Median 5 Mode 6				Standard deviation; 3.1			

*Note 'Family relationships' and 'Marital problems' were combined into a single category for most purposes. The number of events for the combined category was 212, the percentage 42%.

TABLE A9/2.5

NURSES' ACTIVITIES AT NURSE-CLIENT CONTACTS: FOURFOLD-POINT (PHI) CORRELATIONS BETWEEN ACTIVITY CATEGORIES

	Activity categories	1	2	3	4	5	6
1	Personal services		188	-	166	143	-
2	Provide transport	188		-	365	-	491
3	Technical nursing	-	-		-	160	-
4	Joint activities	166	365	-		125	139
5	Social activities	143	-	160	125		-
6	Control activities	-	491	-	139	-	

Decimal points have been omitted

Significance levels for N = 500 are: .05, ϕ = .100 (two-tailed tests)
.01, ϕ = .122

Values of ϕ which do not reach significance at the 5% level have been omitted.

Items on the check-list (Annex 4/3.2) have been amalgamated into categories as follows:

'Personal services' include "wash, bath, shave patient, wash/dress hair, change clothes"; "prepare or serve food or drink"; and "other" personal services.

'Technical nursing' includes "give injection"; "administer drugs by other route"; "any other technical nursing procedure".

'Joint activities' include "Personal grooming, care of clothes"; "domestic tasks in house or garden"; "using public facilities and services (e.g., buses, telephone, shops, library, etc.)"; "other" joint activities.

'Control activities' include "Tracing patient's whereabouts"; "escorting patient to hospital or elsewhere"; "using physical restraint to control patient's behaviour".

TABLE A9/2.6

NURSES' ACTIVITIES AT NURSE-CLIENT CONTACTS: FOURFOLD-POINT (PHI) CORRELATIONS BETWEEN AREAS OF OBSERVATION

	Observation Areas	1	2	3	4	5	6	7
1	Treatment situation		582	292	314	-	148	130
2	Response to medication/treatment	582		308	277	-	-	143
3	Physical health/ condition	292	308		286	102	140	-
4	Mental state	314	277	286		127	172	-
5	Behaviour	-	-	102	127		155	219
6	Material/environmental/	148	-	140	172	155		100
7	Family relationships	130	142	-	-	219	100	

Decimal points have been omitted.

Values of Phi which do not reach significance at the 5% level are not shown.

TABLE A9/2.7

NURSES' ACTIVITIES AT NURSE-CLIENT CONTACTS
FOURFOLD-POINT (PHI) CORRELATIONS BETWEEN
INTERPERSONAL PROCEDURES

Interpersonal Procedures	1	2	3	4	5	6	7	8	9	10	11
1 Express sympathetic interest etc.		-	342	-	322	187	-	-	-	-	-
2 Systematic questioning	-		235	250	-	105	169	170	-	180	159
3 Friendly conversation	342	235		188	247	231	156	127	-	137	127
4 Advise/criticise/ persuade/warn	-	250	188		-	223	463	170	167	404	177
5 Encourage ventilation of feeling	322	-	247	-		144	117	150	151	-	-
6 Information/explanation/instruction	187	105	231	223	144		187	-	132	217	302
7 Encourage careful thought	-	169	156	463	117	187		163	253	384	157
8 Respond to disturbed talk	-	170	127	170	150	-	163		-	141	-
9 Interpret patterns of response/ behaviour	-	-	-	167	151	132	253	-		200	-
10 Authoritative/ directive manner	-	180	137	404	-	217	384	141	200		115
11 Practical help or referral	-	159	127	177	-	302	157	-	-	115	

TABLE A9/2.8

NURSES' ACTIVITIES AT NURSE-CLIENT CONTACTS:
FOURFOLD-POINT (PHI) CORRELATIONS BETWEEN TOPICS

TOPICS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1 Physical health, etc.		238	199	-	287	114	195	-	188	-	-	-	-	-	-	-	147	-
2 Mental state	238		250	208	370	237	164	235	306	125	104	-	-	-	-	-	326	-
3 Personal appearance	199	250		142	228	156	-	163	153	101	109	-	103	-	-	100	202	156
4 Behaviour problems	-	208	142		238	222	162	-	156	190	264	-	198	124	-	180	332	126
5 Medical/psychiatric treatment	287	370	228	238		294	196	-	208	244	111	132	119	-	-	-	294	-
6 Attitude to hospitals	114	237	156	222	194		105	150	254	170	-	153	-	-	-	-	108	-
7 Dependence on drugs etc.	195	164	-	162	196	105		-	-	176	-	-	-	-	-	149	-	-
8 Activities/hobbies/social life	-	235	163	-	-	150	-		257	171	-	-	-	-	-	-	163	-
9 Social isolation, loneliness	188	306	153	156	208	254	-	257		179	-	193	-	-	-	121	134	126
10 Work, employment	-	125	101	190	244	170	176	171	179		-	238	302	-	135	109	128	-
11 Care of children	-	104	109	264	111	-	-	-	-	-		-	291	114	-	103	286	-
12 Housing	-	-	-	-	132	153	-	-	193	238	-		308	152	187	126	-	126
13 Financial matters, budgeting	-	-	103	198	119	-	-	-	-	302	291	308		246	175	148	174	180
14 Legal matters	-	-	-	124	-	-	-	-	-	-	114	152	246		-	165	-	100
15 Health and social welfare services	-	-	-	-	-	-	-	-	-	135	-	187	175	-		-	-	-
16 Sexual problems	-	-	100	180	-	-	149	-	121	109	103	126	148	165	-		-	-
17 Family relationships and marital problems	147	326	202	332	294	108	-	163	134	128	286	-	174	-	-	-		-
18 Other interpersonal relationships	-	-	156	126	-	-	-	-	126	-	-	126	180	100	-	-	-	

Decimal points have been omitted.
Values of Phi which do not reach significance at the 5% level are not shown.

TABLE A9/2.9

FOURFOLD-POINT (PHI) CORRELATIONS OF TOPICS AND AREAS OF OBSERVATION

TOPICS	AREAS OF OBSERVATION						
	Treatment situation	Response to treatment	Physical health/condition	Mental state	Behaviour	Material/environmental/ social circumstances	Family relationships
Physical health	249	249	560	119	-	141	-
Mental state	285	252	125	247	-	237	233
Personal appearance	186	197	200	-	125	216	131
Behaviour problems	-	-	-	-	248	-	330
Medical /psychiatric treatment	360	280	186	197	171	232	243
Attitude to hospitals	169	151	-	182	198	128	167
Drug dependence	120	-	147	-	127	-	115
Activities/hobbies/ social life	208	196	140	308	-	189	-
Isolation/loneliness	195	156	177	167	-	213	-
Work, employment	-	104	-	108	117	185	102
Care of children	-	-	*195	-	-	114	204
Housing	-	-	-	-	-	236	-
Finances	-	-	-	-	-	212	132
Legal matters	-	-	-	-	-	-	-
Health and social welfare services	-	-	-	-	-	-	-
Sexual problems	-	-	-	-	119	-	-
Family relationships/ marital problems	144	-	-	-	-	157	325
Other relationships	-	-	-	-	-	114	191

*Correlation denotes negative association.

Values of Phi which do not reach significance at the 5% level are not shown.

TABLE A9/2.10

FOURFOLD-POINT (PHI) CORRELATIONS OF TOPICS AND INTERPERSONAL PROCEDURES

TOPICS	INTERPERSONAL PROCEDURES										
	Sympathetic interest etc.	Systematic questioning	Friendly conversation	Advise, criticise, etc.	Allow ventilation	Information/explanation	Encourage careful thought	Respond to disturbed talk	Interpretation	Use authority, direction	Offer assistance/referral
Physical health	279	-	*126	127	148	-	-	-	-	-	-
Mental state	331	100	*267	113	423	195	128	204	-	-	-
Personal appearance	186	-	-	130	222	161	119	-	-	119	-
Behaviour problems	-	163	*174	303	263	173	316	157	237	198	157
Medical/psychiatric treatment	265	208	*233	275	231	294	211	147	111	-	231
Attitude to hospitals	171	179	*199	150	231	195	174	196	191	157	-
Drug dependence	-	181	-	241	-	157	146	-	111	129	163
Activities/hobbies/ social life	266	-	-	-	300	-	-	-	-	-	-
Isolation, loneliness	274	-	*174	-	312	212	161	-	109	-	-
Work, employment	181	130	*123	132	113	225	189	-	157	-	-
Care of children	-	-	*114	-	192	-	139	201	-	-	-
Housing	120	-	*137	-	114	175	134	-	115	-	-
Finances	112	-	-	134	144	133	181	112	-	-	114
Legal matters	-	-	-	-	-	-	155	-	-	120	101
Health and social welfare services	-	118	-	-	-	197	156	-	-	-	105
Sexual problems	115	-	-	157	142	-	113	-	170	-	106
Family relationships/ marital problems	187	133	*142	113	353	123	177	-	-	-	-
Other relationships	-	-	-	-	203	-	-	125	-	-	-

*Correlation denotes negative association.
Values of Phi which do not reach significance at the 5% level are not shown.

ANNEX 9/3

PROCESS AND CONTENT OF NURSE-CLIENT INTERACTION
NUMBER OF RESPONSES RECORDED IN FOUR GROUPS OF ITEMS IN RELATION TO OTHER VARIABLES

List of Tables

ANNEX 9/3

PROCESS AND CONTENT OF NURSE-CLIENT INTERACTION: NUMBER OF RESPONSES RECORDED IN FOUR GROUPS OF ITEMS IN RELATION TO OTHER VARIABLES

The total number of responses per contact in each of the main functional groups - i.e., Activities, Observation, Interpersonal Procedures and Topics - was calculated for each contact. The results were related to the following variables: -

(a) the initiator of the contact,

(b) the clients present at the contact, viz., the identified patient only, the patient with members of his family, or family member(s) only,

(c) a broad diagnostic classification, viz., schizophrenic type of illness or other diagnostic category.

The number of Topics items was related also to the sex, age group and social class of the identified patient, and to the sex of the reporting nurse.

(a) Initiator of contact

Contacts initiated by psychiatrists were compared with those initiated by community psychiatric nurses, and both together were compared with those initiated by ward nurses. The detailed findings are shown in Table A9/3.1.

TABLE A9/3.1 /

TABLE A9/3.1

NUMBER OF ITEMS IN EACH FUNCTIONAL GROUP RECORDED PER CONTACT, BY INITIATOR OF CONTACT

(number and percentage of contacts)

		INITIATOR OF CONTACT							
		Community Nurse		Ward Nurse		Psych-iatrist			
		(n)	%	(n)	%	(n)	%	(n)	%
Activities items: number recorded per contact	0	(198)	56	(9)	35	(42)	54	(249)	54
	1	(119)	33	(7)	27	(22)	29	(148)	32
	2+	(39)	11	(10)	38	(13)	17	(62)	14
		(356)		(26)		(77)		(459)	
Observation areas: number recorded per contact	0-2	(67)	19	(11)	42	(19)	25	(97)	21
	3-5	(228)	64	(12)	46	(38)	49	(278)	61
	6+	(61)	17	(3)	12	(20)	26	(84)	18
		(356)		(26)		(77)		(459)	
Interpersonal procedures: number record-ed per contact	0-1	(96)	27	(7)	27	(12)	16	(115)	25
	2-4	(210)	59	(14)	54	(34)	44	(258)	56
	5+	(50)	14	(5)	19	(31)	40	(86)	19
		(356)		(26)		(77)		(459)	
Topics: number recorded per contact	0-3	(120)	34	(18)	69	(19)	25	(157)	34
	4-6	(143)	40	(7)	27	(28)	36	(178)	39
	7+	(93)	26	(1)	4	(30)	39	(124)	27
		(356)		(26)		(77)		(459)	

Relatively high numbers of interpersonal procedures were recorded at contacts initiated by psychiatrists:

TABLE A9/3.2

NUMBER OF INTERPERSONAL PROCEDURES PER CONTACT IN RELATION TO INITIATION BY PSYCHIATRIST OR COMMUNITY PSYCHIATRIC NURSE
(number of contacts)

Number of procedures recorded	Initiator of Contact		
	Community Psychiatric Nurse	Psychiatrist	
0-1	(96)	(12)	(108)
2-4	(210)	(34)	(244)
5+	(50)	(31)	(81)
	(356)	(77)	(433)

χ^2 28.913, 2df., $p < 0.01$.

There was a trend also (not reaching significance at the 5% level) for higher numbers of Observations and Topics to be reported where the contact was initiated by a psychiatrist. No difference was apparent in the case of Activities items. (For detailed results see Table A9/3.1.)

It appears from this table that, at contacts initiated by ward nurses, the number of Activities items recorded was relatively high, while the numbers of Observations and Topics tended to be lower. These differences have been tested using χ^2 tests, and all are significant, at the 1%, 5% and 1% levels respectively.

(b) Clients present at contact

The type of client or client group seen by the nurse at the contact/

contact (viz: patient, family member(s), or both together) was not associated with significant differences in the number of items recorded in the Activities, Interpersonal Procedures and Topics groups; but significantly higher numbers of Observation areas were recorded on occasions when the patient was seen together with a family member or members.[ø]

TABLE A9/3.3

NUMBER OF OBSERVATION AREAS PER CONTACT
BY TYPE OF CLIENTS PRESENT
(number of contacts)

Number of Observation areas recorded	Clients present		
	Patient and family	Patient or family member(s)	
0-2	(16)	(95)	(111)
3-5	(98)	(200)	(298)
6+	(36)	(55)	(91)
	(150)	(350)	(500)

χ^2 17.817, 2df., $p < 0.01$.

Detailed findings are shown in Table A9/3.4

TABLE A9/3.4 /

[ø] This finding does not seem to have been due to greater communicativeness on the part of family members, since higher numbers were not found when family members only were seen.

TABLE A9/3.4

NUMBER OF ITEMS IN EACH FUNCTIONAL GROUP RECORDED PER CONTACT, BY CLIENT(S) PRESENT
(number and percentage of contacts)

		TYPE OF CLIENT(S) PRESENT							
		Patient and family		Patient only		Family only			
		(n)	%	(n)	%	(n)	%	(n)	%
Activities items: number recorded per contact	0	(75)	50	(181)	56	(20)	69	(276)	55
	1	(51)	34	(97)	30	(8)	28	(156)	31
	2+	(24)	16	(43)	13	(1)	3	(68)	14
		(150)		(321)		(29)		(500)	
Observation areas: number recorded per contact	0-2	(16)	11	(73)	23	(22)	76	(111)	22
	3-5	(98)	65	(193)	60	(7)	24	(298)	60
	6+	(36)	24	(55)	17	(0)	-	(91)	18
		(150)		(321)		(29)		(500)	
Interpersonal procedures: number recorded per contact	0-1	(30)	20	(86)	27	(9)	31	(125)	25
	2-4	(85)	57	(177)	55	(15)	52	(277)	55
	5+	(35)	23	(58)	18	(5)	17	(98)	20
		(150)		(321)		(29)		(500)	
Topics: number recorded per contact	0-3	(40)	27	(123)	38	(13)	45	(176)	35
	4-6	(61)	41	(117)	36	(8)	28	(186)	37
	7+	(49)	33	(81)	25	(8)	28	(138)	28
		(150)		(321)		(29)		(500)	

(c) Diagnostic category

Table A9/3.5 shows that more numerous Activities items were recorded in cases involving schizophrenic than non-schizophrenic patients. Fewer Interpersonal procedure items and Topics were recorded where schizophrenic patients were involved. There was no difference between diagnostic categories in the number of Observation areas recorded.

(TABLE A9/3.5 on next page)

(d) Other variables in relation to Topics

Significantly higher numbers of Topics were recorded by female than by male participants:

TABLE A9/3.6

NUMBER OF TOPICS PER CONTACT BY SEX OF RECORDING NURSE
(number and percentage of contacts)

Number of Topics recorded	Sex of recording nurse					
	Male		Female			
	(n)	%	(n)	%	(n)	%
0-3	(110)	55	(66)	22	(176)	35
4-6	(50)	25	(136)	45	(186)	37
7+	(40)	20	(98)	33	(138)	28
	(200)		(300)		(500)	

χ^2 57.304, 2df., $p < 0.01$.

Higher numbers of Topics were also likely to be recorded in cases where a female patient was concerned:

TABLE A9/3.7 /

TABLE A9/3.5

NUMBER OF ITEMS IN EACH FUNCTIONAL GROUP RECORDED PER CONTACT, BY PATIENT'S DIAGNOSTIC GROUP

(number and percentage of contacts)

		DIAGNOSTIC GROUP OF PATIENT					
		Schizophrenic		Not schizophrenic			
		(n)	%	(n)	%	(n)	%
Activities items: number recorded per contact	0	(97)	49	(179)	60	(276)	55
	1	(68)	34	(88)	29	(156)	31
	2+	(34)	17	(34)	11	(68)	14
		(199)		(301)		(500)	
		χ^2 6.312, 2df., $p < 0.05$					
Observation areas: number recorded per contact	0-2	(48)	24	(63)	21	(111)	22
	3-5	(117)	59	(181)	60	(298)	62
	6+	(34)	17	(57)	19	(91)	18
		(199)		(301)		(500)	
		χ^2 0.737, 2df., not significant					
Interpersonal procedures: number recorded per contact	0-1	(63)	32	(62)	21	(125)	25
	2-4	(103)	52	(174)	58	(277)	55
	5+	(33)	17	(65)	22	(98)	20
		(199)		(301)		(500)	
		χ^2 8.114, 2df., $p < 0.05$					
Topics: number recorded per contact	0-3	(85)	43	(91)	30	(176)	35
	4-6	(69)	35	(117)	39	(186)	37
	7+	(45)	23	(93)	31	(138)	28
		(199)		(301)		(500)	
		χ^2 8.769, 2df., $p < 0.05$					

TABLE A9/3.7

NUMBER OF TOPICS PER CONTACT, BY SEX OF PATIENT
(number and percentage of contacts)

Number of Topics recorded	Sex of patient					
	Male		Female			
	(n)	%	(n)	%	(n)	%
0-3	(77)	44	(99)	30	(176)	35
4-6	(61)	35	(125)	38	(186)	37
7+	(36)	21	(102)	31	(138)	28
	(174)		(326)		(500)	

χ^2 11.160, 2df., $p < 0.01$.

Higher numbers of Topics were less likely to be recorded where the patient was 65 years old or more:

TABLE A9/3.8

NUMBER OF TOPICS PER CONTACT, BY AGE OF PATIENT
(number and percentage of contacts)

Number of Topics recorded	Age of patient					
	65		65+			
	(n)	%	(n)	%	(n)	%
0-3	(132)	33	(44)	43	(176)	35
4-6	(140)	35	(45)	44	(185)	37
7+	(124)	31	(14)	14	(138)	28
	(396)		(103)		(499)	

χ^2 12.799, 2df., $p < 0.01$.

No significant difference was apparent between patients in social classes I, II and III, and in classes IV and V.

PROCESS AND CONTENT OF NURSE-CLIENT INTERACTION

List of contact-situation variables associated with differences in the frequency with which check-list items were recorded

NOTES

1. Associations between variables and items were tested using standard Chi-square tests.
2. Associations are not included in the list unless the probability of their occurring by chance was less than 5% (or 1 in 20). Where the probability of chance occurrence was less than 1 in 100, the item is marked with an asterisk.
3. Groups of items are quoted in the order used throughout this report - viz.
    1. Activities
    2. Observation areas
    3. Interpersonal procedures
    4. Topics.

    They are designated, respectively, by the letters A, O, P and T.

(1) Features of contact situation		(2) Association with items from check-list	
CLIENTS PRESENT AT CONTACT			
Patient plus family	More likely	O *	Family relationships
		P	Offer practical help or referral
		T	Mental state, symptoms, etc.
Patient alone	More likely	T *	Social isolation, loneliness
	Less likely	T *	Family relationships and marital problems
		T	Health and social welfare services
Family member(s) only	More likely	T *	Behaviour problems and management
	Less likely	O *	(All O items except family relationships)
		P *	Express sympathetic interest, etc.
		T *	Medical/psychiatric treatment
		T *	Personal appearance
PATIENT'S STATUS AT PARENT HOSPITAL			
Out-patient	More likely	A	Technical nursing
		O *	Mental state
		O *	Response to treatment
		O *	Treatment situation
		O *	Material/environmental circumstances
		O	Family relationships
		P *	Express sympathetic interest
		P *	Allow ventilation
		P *	Encourage careful thought
		T *	Mental state, symptoms, etc.
		T *	Medical/psychiatric treatment
		T	Attitude to hospitals, etc.
		T	Personal appearance
		T *	Behaviour problems and management
		T *	Work, employment
		T *	Family relationships and marital problems
Community patient/			

(1) Features of contact situation		(2) Association with items from check-list
Community patient	More likely	O * Physical health, condition
		P * Friendly social conversation
	Less likely	P Information, explanation
		P * Systematic questioning
		P * Respond to disturbed talk
		P * Use authoritative/directive manner
		T * Legal problems
In-patient or day patient	More likely	A * Joint activities
		A * Providing Transport
		A * Control activities
		P * Advise, warn, etc.
	Less likely	T * Activities, hobbies, social life
		T * Physical health, symptoms, etc.
INITIATOR OF CONTACT		
Community psychiatric nurse	More likely	O * Response to treatment
		P * Friendly social conversation
		T * Activities, hobbies, social life
Psychiatrist	More likely	O * Patient's behaviour
		O Family relationships
		P Information, explanation, etc.
		P * Offer practical help, referral
		P * Systematic questioning
		P * Encourage careful thought
		P * Interpret dynamics, etc.
		T * Mental state, symptoms, etc.
		T Attitude to hospitals, etc.
		T Behaviour problems and management
		T * Family relationships and marital problems
		T Work, employment
		T Housing
Ward nurse	More likely	A * Providing transport
		A * Control activities
	Less likely	T Physical health, symptoms, etc.
		T Medical/psychiatric treatment
		T * Personal appearance
		T Financial matters, budgeting

INITIAL CONTACT? /

(1) Features of contact situation		(2) Association with items from check-list	
INITIAL CONTACT?			
Yes!	More likely	O	Material/environmental circumstances
		P *	Information, explanation etc.
		P	Systematic questioning
		P	Respond to disturbed talk
		P *	Interpret dynamics, etc.
CHANGE IN PATIENT'S BEHAVIOUR/ CONDITION NOTED?			
Improvement	Less likely	P	Allow ventilation
Deterioration	More likely	P	Systematic questioning
		P *	Advise, criticise, etc.
		P *	Offer practical help or referral
		P *	Respond to disturbed talk
		P *	Use authoritative/directive manner
		P	Encourage careful thought
		P *	Interpret dynamics etc.
	Less likely	P	Friendly social conversation
Any change, for better or worse	More likely	O *	Patient's behaviour
		O	Response to treatment
CAUSE OF STRESS TO PATIENT NOTED?			
Yes!	Less likely	O *	Response to treatment
		O	Treatment situation
		O *	Mental state
		O	Family relationships
DYADIC INTERACTION?			
Yes!	More likely	P	Express sympathetic interest, etc.
	Less likely	P	Information, explanation etc.
		P *	Offer practical help or referral
		P *	Use authoritative/directive manner

ANNEX 9/5

PROCESS AND CONTENT OF NURSE-CLIENT INTERACTION

List of patient-characteristics associated with differences in the frequency with which check-list items were recorded.

NOTES

1. The characteristics were those which obtained at the time of the patient's key contact.
2. Associations between characteristics and items were tested using standard Chi-square tests.
3. Associations are not included in the list unless the probability of their occurring by chance was less than 5% (or 1 in 20). Where the probability of chance occurrence was less than 1 in 100, the item is marked with an asterisk.
4. Groups of items are quoted in the order used throughout this report - viz.
    1. Activities
    2. Observation areas
    3. Interpersonal procedures
    4. Topics.

    They are designated, respectively, by the letters A, O, P and T.

(1) Characteristics of identified patient		(2) Association with items from check-list	
SEX			
Male	More likely	P *	Systematic questioning
		T *	Work, employment
Female	More likely	A *	Social activities, hospitality
		P *	Allow ventilation
		T *	Mental state, symptoms, etc.
		T	Medical/psychiatric treatment
		T	Personal appearance
		T *	Family relationships and marital problems
		T *	Care of children
AGE GROUP			
Under 45	More likely	A *	Control (non-schizophrenic patients only)
		O	Patient's behaviour
		O *	Physical health/condition
		O	Family relationships
		T	Medical/psychiatric treatment
		T	Family relationships and marital problems
		T *	Sexual problems
		T *	Care of children (women only)
	Less likely	O	Treatment situation
Under 65	More likely	A *	Technical nursing (non-schizophrenic patients only)
		P *	Information, explanation etc.
		P	Systematic questioning
		P *	Advise, criticise, etc.
		P *	Encourage careful thought
		T	Attitude to hospitals, etc.
		T *	Behaviour problems and management
		T *	Financial matters, budgeting
65+	More likely	A	Social activities, hospitality
		A *	Personal service
		P *	Friendly social conversation
		T *	Physical health, symptoms, etc.
		T	Activities, hobbies, social life
		T *	Social isolation, loneliness

SOCIAL CLASS/

(1) Characteristics of identified patient		(2) Association with items from check-list	
SOCIAL CLASS			
I, II and III	More likely	O *	Mental state
		O	Physical health/condition
		O	Treatment situation
		P *	Express sympathetic interest, etc.
		P *	Allow ventilation, etc.
		P *	Interpret dynamics, etc.
		T *	Mental state, symptoms, etc.
		T	Attitude to hospitals, etc.
		T *	Activities, hobbies, social life
		T *	Social isolation, loneliness
IV and V	More likely	A *	Technical nursing (non-schizophrenic patients only)
		A	Personal service
		P *	Systematic questioning
		P	Offer direct help/referral
DIAGNOSTIC GROUP			
Schizophrenic	More likely	A *	Technical nursing
		A *	Control activities
		O	Response to treatment
		T *	Work, employment
Non-schizophrenic	More likely	A *	Social activities, hospitality
		O	Family relationships
		P *	Allow ventilation, etc.
		P *	Interpret dynamics, etc.
		T *	Physical health, symptoms, etc.
		T *	Mental state, symptoms, etc.
		T	Personal appearance
		T	Behaviour problems and management
		T	Social isolation, loneliness
		T *	Family relationships and marital problems
		T *	Other relationships
		T	Financial matters, budgeting
		T	Legal matters

DURATION OF PAST/

(1) Characteristics of identified patient		(2) Association with items from check-list	
DURATION OF PAST PSYCHIATRIC HISTORY			
Short (less than 1 year since first psychiatric admission)	More likely	A	Social activities, hospitality
		A	Control activities
		P	Respond to disturbed talk
		T *	Mental state, symptoms, etc.
	Less likely	P *	Use authoritative /directive manner
		T	Work, employment
		T	Housing
Medium (not more than 5 years since first psychiatric admission)	More likely	O *	Physical health/condition
		O	Family relationships
		P *	Systematic questioning
		P *	Advise, criticise, etc.
		P	Offer practical help or referral
		T	Physical health, symptoms, etc.
		T *	Medical/psychiatric treatment
		T *	Behaviour problems and management
		T *	Family relationships and marital problems
Long (more than 5 years since first psychiatric admission)	More likely	A	Joint activities
DATE OF LATEST DISCHARGE FROM PSYCHIATRIC HOSPITAL			
Up to 1 year ago	More likely	A	Control activities
		O	Family relationships
		P *	Information, explanation, etc.
		P *	Systematic questioning
		P	Use authoritative/directive manner
		T	Mental state, symptoms, etc.
		T *	Attitude to hospitals, etc.
		T	Family relationships and marital problems
Over 1 year ago	More likely	A	Joint activities
		T	Activities, hobbies, social life

ANNEX 12

NURSES' PERCEPTION OF THEIR FUNCTIONS

LIST OF TABLES

TABLE A12/1 NURSES' PERCEPTION OF THEIR FUNCTIONS: CLASSIFICATION OF RESPONSES ABOUT AIMS AND METHODS

(percentage and number of cases)

Categories of Function	%	(n)
Group 1: Clinical	61	(67)
Group 2: Psycho-social	60	(65)
Group 3: Environmental	19	(21)
Group 4: Internal liaison	13	(14)
Group 5: External liaison	17	(18)
No aim stated or response not classifiable	6	(7)

Notes : (1) N = 109 (Answers not available from 2 interviews)

(2) The categories were not mutually exclusive; up to 5 could be used in any one case.

TABLE A12/2: NURSES' PERCEPTION OF THEIR FUNCTIONS: EXPRESSED AIMS AND METHODS IN RELATION TO LOCATION OF CONTACTS IN EACH CASE

(number of cases)

Nurses' expression of aims and methods	LOCATION OF CONTACTS			TOTAL
	1 Always at injection clinic	2 Mixed - clinics/ elsewhere	3 Always elsewhere	
Concerned with patients' relatives	2	5	11	18
Not concerned with patients' relatives	14	27	50	91
Clinical function (Group 1) expressed	16*	27*	24*	67*
Clinical function (Group 1) not expressed	-	5*	37*	42*
Psycho-social function expressed	8ø	14ø	43ø	65ø
Psycho-social function not expressed	8ø	18ø	18ø	44ø

* X^2 26.543, d.f. 1, $p < 0.01$ (combining cols. 1 and 2)

ø X^2 6.958, d.f. 2, $p < 0.05$

TABLE A12/3 NURSES' PERCEPTION OF THEIR FUNCTIONS: EXPRESSED AIMS AND METHODS IN RELATION TO PERSONS SEEN AT CONTACTS (number of cases)

Nurse's expression of aims and methods	Persons present at >50% of contacts in case		TOTAL
	Patient alone	Patient plus family/ Family alone/ other combination	
Concerned with patient's relatives	11*	7*	18*
Not concerned with patient's relatives	78*	13*	91*
Clinical function (Group 1) expressed	59Ø	8Ø	67Ø
Clinical function (Group 1) not expressed	30Ø	12Ø	42Ø
Psycho-social function (Group 2) expressed	49	16	65
Psycho-social function (Group 2) not expressed	40	4	44

* X^2 4.540. d.f. 1, $p < 0.05$

Ø X^2 3.720, d.f. 1, $p > 0.05$

TABLE A12/4

CLIENTS' PROBLEMS: OBSERVATION AND INTERVENTION BY NURSES
(Number of cases)

PROBLEM	OBSERVED BY NURSE	DEALT WITH BY NURSE			
		% of no. observed	Total	By direct care	By referral
Intra-family relationships (other than marital problems)	67	52%	35	29	6
Personality problems, inadequacy	66	36%	24	19	5
Distress, anxiety or strain arising from the patient's mental state or behaviour	57	77%	44	37	7
Lack of social contact, loneliness, seclusiveness	56	45%	25	7	18
Difficulties in coping with everyday activities, travel, housework, etc.	52	58%	30	21	9
Neglect of self-care	41	54%	22	15	7
Housing/accommodation problems	36	61%	22	9	13
Coping with physical illness/ disability	35	40%	14	7	7
Difficulties of finding/keeping jobs	33	48%	16	12	4
Financial difficulties	33	39%	13	2	11
Restriction or disruption of social life/employment/ domestic duties	26	50%	13	10	3
Marital relationships	23	35%	8	8	-
Mental disorder in household member other than patient	23	13%	3	1	2
Difficulties in care/management of children	20	40%	8	-	8
Misuse of drugs or alcohol	17	35%	6	2	4
Crime, delinquency, conflict with authority	15	21%	3	-	3
Bereavement	13	92%	12	10	2
Legal problems	9	78%	7	3	4
Problems of sexual behaviour (other than marital problems)	6	67%	4	2	2

N = 111 (sample cases, interview data)

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